THE USE OF DREAMWORK WITH THE BONNY METHOD OF GUIDED IMAGERY AND MUSIC: A SURVEY OF CURRENT PRACTICE

A Thesis
by
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ABSTRACT

THE USE OF DREAMWORK WITH THE BONNY METHOD OF GUIDED IMAGERY AND MUSIC: A SURVEY OF CURRENT PRACTICE (May 2012)

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The purpose of this study was to examine current uses of clinical dreamwork with the Bonny Method of Guided Imagery and Music (GIM) and to explore clinical examples of using dreams in GIM sessions. Clinical dreamwork is well documented in the psychotherapy literature, but very little is known about the use of dreamwork within the GIM session. A mixed method design was used to provide a fuller picture of how dreamwork may be implemented within GIM sessions. A questionnaire was constructed using GoogleDocs and e-mailed to 266 GIM therapists who were invited to complete the questionnaire related to their current practice of dreamwork within GIM sessions. The focus of this questionnaire was to determine how frequently dreamwork was used with GIM, what methods were used, the theoretical orientation of the therapist, therapist attitudes toward dreamwork, and what education and training served as their sources of knowledge in dreamwork methods. A total of 61 respondents from 19 countries completed the *Dreamwork with Guided Imagery and Music Questionnaire*, a response rate of 24%. Respondents reported working with dreams in GIM an average of 21.61% (SD = 16.88) of their sessions. The theoretical orientation most endorsed by the respondents was humanistic/existential. In regards to training in dreamwork,

38% of the respondents reported little to no training, 26% reported moderate training, and 28% reported higher to extensive training; the two highest reported types of training were "reading" and "workshops/seminars." GIM therapists who reported more training also felt more competent in dreamwork ($r = 0.82$; $p < 0.001$); additionally, those respondents who reported higher levels of training also endorsed the importance of working with dreams in therapy ($r = 0.33$; $p = 0.007$). Therapists who valued their dreams were found to use multiple dreamwork activities within GIM. Respondents also reported personal examples of using dreamwork with GIM and shared their professional opinions on the therapeutic use of dreamwork with GIM. This study provides a representation of how dreams are currently used with GIM. The results point to areas for future study and suggest the potential need for additional dreamwork training for GIM therapists.

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CHAPTER 1

INTRODUCTION

Clinical dreamwork, sometimes referred to as dream interpretation, is using dreams within a therapeutic setting and has been shown to be an effective tool in psychotherapy (Hill, 1996). This study will use the term dreamwork, as it implies a greater use for dreams other than simply interpreting the content. Psychotherapists may work with dreams in different contexts, such as exploring nightmares, and within different theoretical frameworks, such as Freudian, Jungian, Gestalt, or Adlerian (Crook & Hill, 2003; Eudell-Simmons & Hilsenroth, 2007; Keller et al., 1995). The essential feature of dreamwork is to bring awareness to one's images and derive meaning from them. The Bonny Method of Guided Imagery and Music (GIM) is a method of psychotherapy that combines imagery with music listening and utilizes the evocative nature of music to explore altered states of consciousness (Bonny, 2002a; Bonny 1975/2002b). Both dreamwork and GIM utilize images to facilitate insight, to inspire therapeutic change, and to explore client's lives. This chapter offers an overview of the literature describing imagery in psychotherapy, a brief explanation of current research in sleep and dreams, methods and theoretical orientations for clinical dreamwork, survey research in dreamwork and psychotherapy, an explanation of GIM, and a review of dreamwork in GIM.

Imagery in Psychotherapy

Psychotherapists use imagery in a variety of ways. Singer (2006) explored the history of imagery for meaning making and the importance of imagery in memory, experience, and sensing the environment. Singer also looked at the value of personal narrative and the universal human characteristic of sharing stories. Many psychotherapy sessions begin with the client telling his/her story. Singer described the use of imagery in cognitive-behavioral therapy, specifically in systematic desensitization and using positive imagery to counteract anxiety-provoking thoughts (pp. 110-115). These uses of imagery typically are "induced imagery" (p. 118) that the psychotherapist determines and gives to the client to work with. Singer goes on to explore other uses of imagery in psychotherapy, such as relaxation. During relaxation with imagery Singer stated that the client, within the safe therapeutic environment, is empowered to connect to images that he/she may use for future relaxation or for positive reinforcement of inner resources (p. 171). Singer also described using imagery in psychotherapy to increase creativity. Singer acknowledged the imagery world of dreams and potential for some therapeutic goals, but believed that dream interpretations were more akin to Rorschach's inkblot tests or Freud's free association technique and thus unlikely to indicate little if any relation to the client's current waking life (p. 177). He continued, however, to encourage the reader, presumably a therapist, to direct the client's attention to his/her dreams should that client have difficulty creating imagery. Singer provided examples of ways to encourage imagery in clients who report difficulty when using his/her imagination. He concluded by emphasizing the importance of therapists' imagery during the treatment process. In Singer's opinion, imagery is "central to the ways in which we make sense of our world more generally" (p. 185).

Another example of using imagery in psychotherapy is in expressive arts therapy. Expressive art therapy incorporates imagery into therapy through "storytelling, dance, music, drama, poetry, movement, dreamwork, and visual arts…to foster human growth, development, and healing" (Atkins et al., 2003, pp. 3-4). Expressive arts therapists use imagery and metaphor to encourage clients to engage in their world differently and to view new, unexpected perspectives.

Clinical Dreamwork in Psychotherapy

Therapists from several orientations use clinical dreamwork, which has been shown to effectively facilitate positive therapeutic outcomes. Dreamwork is a specific imagery technique that incorporates language and metaphor and relates dream aspects to current life situations. As Hill (1996) wrote, "The language of dreaming seems to make use of two essentially human communication characteristics: the use of metaphors and our propensity to tell stories" (p. 48). Hill provided a resource for psychotherapists who wish to incorporate dreamwork into their practice. Hill discussed the use of dreams in brief therapy and the benefits to working with dreams with a therapist rather than on one's own. Hill also cited the importance of training in dreamwork methods as well as the therapist's experiencing dreamwork personally. Hill described a model of dreamwork that incorporates the following three stages: exploration, insight, and action (p. 43). Her book details the therapist's role in each stage, therapeutic techniques (what to do and not to do) that are effective in each stage, and specific therapeutic issues that may arise during each stage. Interest in dreamwork often includes curiosity about sleep and the physiological function of dreaming. The following section will explore research in the field of sleep and dreams, theoretical orientations to

working with dreams, a variety of dreamwork methods, and current survey research in the field of clinical dreamwork in psychotherapy.

Sleep and dreams. Palagini and Rosenlicht (2011) combined historical foundations of psychological and neurobiological theories of dreams with recent research in the field of sleep and dreams, including the notion that dreams are simply a manifestation of neurobiological processes and not psychologically related. They described research that examined the effects of mental illness on the recollection of dreams, noting that clients who are depressed or in a depressive episode of bipolar disorder report fewer dreams than healthy clients in the control group (p. 181). Palagini and Rosenlicht also discussed the use of dreams for assessment and diagnosis for clients with post traumatic stress disorder. The authors explored advances in neuroimaging that have debunked many of the myths about dreaming; for instance, that visual images or dreams occur only during rapid eye movement (REM) sleep. Palagini and Rosenlicht's overview of research shows the significance of and curiosity surrounding sleep and dreams not only for neurobiologists interested in the physiological function of dreams, but also for mental health professionals who seek to understand the nature of psychiatric disorders and the potential relationship to sleep and dreams.

Cartwright (2010), informally known as the "Queen of Dreams" (p. 6), has studied sleep habits, neurophysiology related to sleep, and dreaming. The work of Kleitman (Aserinsky & Kleitman, 1953), the researcher who discovered rapid eye movement (REM) during sleep was the inspiration for Cartwright. In the mid-1960s, Cartwright began conducting sleep studies, including one study that explored the hallucinogenic properties of piperidyl benzilate and compared the drug experience to dreaming (Cartwright, 1966). This study, though later described by the researcher as poorly controlled and naïve (Cartwright,

2010), is similar to Bonny's (2002a; Bonny & Pahnke, 1972/2002) experience with LSD research at the Maryland Psychiatric Research Center that contributed to the development of GIM (see The Bonny Method of Guided Imagery and Music below). Both researchers were interested in the psychopharmacological qualities of the hallucinogenic drug experience as it related to the natural process of dreaming and imagination; Cartwright continued research in the field of dreaming and Bonny developed the method of GIM, sometimes referred to as a waking dream. Cartwright has also studied the effect of depression on dreams and recollection of dreams, specifically in participants who were going through divorce. Cartwright's current dream research has been in the area of sleepwalking, parasomnias, and the relation of dreams to the dreamer's waking life. Hill (1996) described Cartwright's RISC four-step dreamwork method: "1) Recognize: [the client] recognizes when he or she is having a bad dream…. 2) Identify: what it is about the dream that makes him or her feel badly…. 3) Stop the bad dream…. 4) Change: the dream dimensions into their opposite, positive sides" (p. 42). This method, while empowering the client, is more cognitive-behavioral and focuses on "bad" dreams with the intent to change them; it indicates the physiological emphasis of Cartwright's work.

Theoretical orientations and dreamwork methods. There are several theoretical orientations that address dreamwork in psychotherapy. Freud, Jung, and Adler, the early psychoanalysts, provided the first psychological theories of clinical dreamwork. One of the earliest writings about dreams in psychotherapy is Freud's (1900/1999) *The Interpretation of Dreams.* Freud believed that most dreams served as wish-fulfillment for the dreamer and that understanding the dreamer's outer and inner reality could lead to discovery of the latent meaning of dreams. Hill (1996) described the way Freud uncovered layers of consciousness:

"Freud compared the psychoanalyst doing dream interpretation to an archeologist uncovering layer after layer of the psyche before coming to the deepest, most valuable treasures" (p. 31). Freud was one of the first psychologists to describe types of dream symbols, often sexual in nature, examining images in terms of female or male representations (e.g., a cave represented female or feminine; pointed, phallic objects represented male or masculine). One dreamwork method that came from Freud's work with dreams is free association, and therapists still use this method today. Subsequent evidence from using dreams in therapy has not substantiated Freud's other claims regarding dreams as wish-fulfillment or universal symbolic meaning (Hill, 1996). Hill (1996) also pointed out that Freud's approach does not emphasize the relevance to the dreamer's waking life.

Jung (1964; 1969) was a contemporary and correspondent of Freud's but his methods and ideas about dreamwork diverged from Freud's idea that the dream concealed unconscious wishes. Jung believed that dreams illuminated unconscious content rather than hiding it (Hill, 1996; Jung, 1964). He also postulated that symbols were not universal but that archetypes, "the contents of the collective unconscious" were indeed universal (Jung, 1969 p. 4). In fact, Jung coined the terms *personal unconscious* and *collective unconscious*. Additionally, the use of archetypes in dream work is most associated with Jungian dreamwork. These concepts are integral to Jungian psychoanalysis and dreamwork. Hill (1996) pointed out that Jung "encouraged dreamers to represent dream images in various forms of artistic expression" (pp. 32-33). Jacobi (1964) described Jung's treatment of the first dream brought to therapy as an important tool for assessing a client's "psychic conflicts" (p. 329). One of Jung's contributions to the field of clinical dreamwork was the therapeutic value that he placed on dreams; Jung believed that "dreams are positive, normal, and

creative, and can be used to help people achieve a balance in waking life" (Hill, 1996, p. 33). Recent Jungian psychoanalysts including Bosnak (1988), Hall (1983), and Johnson (1986) have provided a contemporary point of view for working with dreams in psychotherapy. Hill (1996) compared her method of dreamwork to Johnson's (1986) four-step method, simply delineated here: "1) Making associations, 2) Connecting dream images to inner dynamics, 3) Interpreting, [and] 4) Doing rituals to make the dream concrete" (p. 51). The fourth step brings together the unconscious with the dreamer's everyday life.

Adler (as cited by Bird, 2005; Dushman & Sutherland, 1997; Hill, 1996) was another contemporary of Freud and, like Jung, his beliefs about dreamwork and about therapy differed from Freud's original assertions. Adler believed that dreams were a means of problem solving and an opportunity for the dreamer to rehearse resolutions (Hill, 1996). Bird (2005) described an Adlerian approach to dreamwork, a contrast to Freud's views on dreams. A salient feature of Adler's approach is that each dreamer is revered "as a holistic being…each individual is creative in all circumstances" (p. 201). Adler viewed dreamwork as important for working through emotions and stated, "Very courageous people dream rarely, for they deal adequately with their situation in the day-time" (p. 202). Dushman and Sutherland (1997) described using an Adlerian approach for a dream group that incorporated other creative arts modalities, including psychodrama and art. This approach emphasized enacting the dream and drawing the dream images; the group dynamics broadened the efficacy of this approach.

Historically, therapists with a cognitive-behavioral orientation tended to work less with dreams in therapy. This was primarily due to the split between cognitive-behavioral therapists, specifically Beck, from the psychoanalytic therapists who emphasized dreams and

the unconscious and because of the previous difficulty in studying dreams (Montanegro, 2009). More recent approaches to dreamwork are, in fact, based on a cognitive approach or contain elements of a cognitive-behavioral orientation (Hill, 1996; Montanegro, 2009). Montanegro described how cognitive-behavioral therapists may approach dreamwork within this framework. Montanegro described dreams from a cognitive standpoint: the act of dreaming is a cognitive act. He also described the Description, Memory sources, and Reformulation method of cognitive-behavioral dreamwork in detail. This method emphasizes immersing the dreamer in the memory of the dream and the association of these memories to real events in life. The therapist also encourages examination of mnemonic sources and feelings presented in the dream. The next step is to have the dreamer re-tell the dream using general terms (e.g., using the phrase "main way to get around" instead of "Highway 321"). In this method, dream interpretation may come in directly following the restatement of the dream using the more generalized language. Illumination may come from the general statements that offer insight into waking life issues. This technique also connects the dream content or message to waking life and encourages action following the dreamwork.

Existential and humanistic psychotherapists, including Gestalt therapists, also use dreams in therapy. Dolias (2010) described an existential perspective to working with dreams, similar to Jung's rejection of Freud's notion of dreams as concealing the unconscious; "Phenomenologically, dreams are not masking one's truth – their true significance lies in that dreams have no disguise: the experience of bad dreams is seen for what it is" (p. 239). Hill (1996) described the goal of using dreams in existential therapy as "to return to the dream as a vital, concrete episode in the being-in-the-world and allow the dreamer to acknowledge and appreciate the experience" (p. 39). Perls (1969), a formative

figure in Gestalt therapy, endorsed the group approach to working with dreams. On the topic of dreamwork, Perls wrote: "I believe that in a dream, we have a clear existential message of what's missing in our lives, what we avoid doing and living, and we have plenty of material to re-assimilate and re-own the alienated parts of ourselves" (p. 76). Gestalt dreamwork often centers on bringing the dream to the present "here-and-now" and engaging in a dialogue with the dream itself as well as with specific images or symbols from the dream.

Atkins et al. (2003) outlined several intermodal and integrative methods for working with dreams in therapy. One method is adapted from the work of psychotherapist Bingham Dai and has five simple steps:

> 1) Tell or write a dream story. Include the date. Write any afterthoughts that come to you. 2) Review the events of the day. 3) Make free associations to all elements of the dream. What does this make you think of? 4) Identify the feeling tone of the dream. 5) Make connections to your current issues or problems in living. (p. 74)

Additional dreamwork methods incorporate expressive arts therapy modalities, including drawing, taking the symbol/feeling into music, drama, or having a dialogue with the dream symbol/person, similar to Gestalt dreamwork. These methods also direct the dreamer to discover what action the dream is indicating for the dreamer to do following the insight.

Eudell-Simmons and Hilsenroth (2007) explored the historic premise to use dreams in psychotherapy, theoretical orientations of dreamwork, and physiological dream research. They created an "Integrative Model" that employs salient features from the prominent areas of dream theory: "classical psychoanalysis, contemporary psychodynamic-interpersonal, existential/gestalt, cognitive-experimental, cognitive-behavioral, physiological, and linguistic" (p. 346). This model uses dreamwork activities from the previously stated models

and emphasizes the dream story. What is interesting is that this model takes into account the physiological research in the field of sleep and dreams and considers the nature of brain activity during dreaming as it relates to life events. Eudell-Simmons and Hilsenroth discussed the integrative model of working with dreams in psychotherapy by describing the individualized nature of therapy, the integration of many dreamwork techniques, and the potential for use in therapy:

> The answers to the question of dream meaning and function have shown both similarities and differences across various theoretical models. The Integrative Model suggests that these similarities necessitate a wider application of therapeutic dream work that current theoretical differences allow for through diverse techniques, terminology, and explanation. Primarily, the integrative approach to understanding dreams emphasizes the relationship of dream content to waking life through its potential to delineate typical personality functioning, to demonstrate salient issues the patient is currently facing and his or her affective responses, and to illustrate interpersonal conflicts and responses to anxiety-provoking situations. The integration of these approaches, utilizing their similarities as well as their differences to tailor treatment for individual patients, has the potential to expand and improve the dream's usefulness and relevance in psychotherapy. (p. 353)

As Eudell-Simmons and Hilsenroth (2007) have shown, dreamwork methods often have more commonalities than differences. When examining the actual dreamwork activities, one method may appear identical to another. For instance, following the telling of a dream therapists often ask the client to associate to the dream image; therapists can use this dreamwork activity in psychoanalytic or cognitive-behavioral oriented therapy. The

theoretical underpinnings determine how the therapist then works with the dream images in a clinical, therapeutic manner. Recent research has set out to determine what dream activities and theoretical orientations psychotherapists are using.

Survey research. Several surveys have examined the use of and training for clinical dreamwork and psychotherapy. Keller et al. (1995) surveyed psychologists to determine the extent of dreamwork in psychotherapy and the theoretical approaches used and to explore how clinicians were trained in dreamwork techniques. The survey was one page and sent to 500 Florida Psychological Association members, of which 228 responded. Keller et al. found that a total of 83% of respondents reported using dreams in therapy "occasionally" (53%), "moderately" (17%), "frequently" (9%), and "almost always" (4%). The most widely used theoretical framework was Gestalt, followed by Freudian, Jungian, and Adlerian. The majority of respondents reported that they do not "introduce dreams or discuss dreams unless the patient takes the initiative" (p. 1289). Graduate training was the most reported method of training with 60% indicating this is a source of their dreamwork education. Second to graduate training was workshops at 40%. (Respondents could have included more than one method for training.) This survey suggested that graduate faculty and supervisors might increase opportunities for experience and supervision in the various therapeutic methods of clinical dreamwork. The researchers noticed that the majority of respondents acquired experience for using dreams in therapy from personal work. This survey was one page and asked basic questions that were easy to answer; the results indicated areas for further research and training.

Schredl, Bohusch, Kahl, Mader, and Somesan (2000) developed a one-page survey regarding psychotherapists' use of dreams in practice as well as use of dreams for personal

growth. The questionnaire was sent to psychotherapists in private practice in Germany with a response rate of 60.3% (N = 79). Schredl et al. found that psychotherapists who reported no training in psychoanalytic techniques used dreamwork less in their practice. Respondents cited Freudian dreamwork as the top method for working with dreams with Jungian dream analysis favored second. They also listed dreamwork training from "literature, personal work on dreams, and seminars" (p. 83). The researchers examined differences between theoretical orientations. They found clear differences between psychoanalytic therapists versus humanistic or cognitive-behavioral therapists: "Psychoanalysts use dreams more often in therapy, regard working on dreams as more beneficial, and report a more pronounced enhancement of dream recall in their patients" (p. 83). The researchers also correlated therapist variables, such as "dream recall" and "frequency of personal work on dreams" with how dreamwork was used in therapy. There was no significant correlation between the therapists' dream recall and how frequently they used dreams in therapy. There was evidence that personal work with dreams correlated highly with the frequency of using dreamwork activities in therapy. This survey illustrated the use of dreams in one particular country with psychoanalytic psychotherapists' attitudes and personal dreamwork indicating a higher likelihood of using dreams in therapy. The survey itself was quite brief and only offered limited responses for multiple choice questions, limiting the scope of the research.

Crook and Hill (2003) surveyed 129 psychologists to "describe and predict how much therapists work with clients' dreams in therapy" (p. 84) and what types of clients are best suited for dreamwork. Crook and Hill built upon the research of Keller et al. (1995) and Schredl et al. (2000) and were more interested in discovering the actual dreamwork methods and activities that psychotherapists used. The researchers developed the *Therapist Dream*

Questionnaire, a six-part, 70-item survey of practices and attitudes. The respondents reported that they spent a median of 5% (range = 0%-33%) of time working with clients' dreams. Therapists who were primarily from a cognitive-behavioral orientation reported feeling moderately confident in working with dreams and a moderate amount of training in dreamwork. The average rating of all respondents indicated moderate feelings of competence with dreamwork ($M = 2.88$, $SD = 1.19$). Crook and Hill found significant intercorrelations between therapists' attitudes, dream interpretation competence, amount of personal dreamwork, dream interpretation training and overall dream activities. "Overall dream activities" were correlated with "attitudes toward dreams" ($r = 0.79$; $p < 0.001$), "dream interpretation competence" ($r = 0.74$; $p < 0.001$), "dream interpretation training" ($r = 0.66$; $p < 0.001$), and "amount of personal dreamwork" ($r = 0.65$; $p < 0.001$). Additionally, Crook and Hill reported that "training in dream work was strongly related to feelings of competence in dream work, a psychodynamic orientation, not having a behavioral orientation, having positive attitudes toward dreams, and having high dream recall" (p. 88).

Crook and Hill (2003) also explored what situations and with what types of clients would psychotherapists use dreamwork and specific dream activities. On a 5-point Likert scale from 1 (*not likely)* to 5 (*very likely*), the highest rated likelihood for working with dreams in therapy was "client presents a troubling dream or nightmare" ($M = 4.24$; $SD = 1.01$) and "client presents recurrent dreams" ($M = 4.19$; $SD = 1.09$). In terms of use of specific dream activities in therapy, Crook and Hill used a 5-point Likert scale rated from 1 (*never)* to 5 (*frequently*) and found that "listen if client brings in dreams" was rated the highest ($M = 4.43$; $SD = 0.98$) and "explore connections of dream images to waking life" was second highest ($M = 3.81$; $SD = 1.24$). "Collaborate with clients to construct dream

interpretation" was rated a mean of 3.51 (*SD* = 1.30). Crook and Hill's results showing the link between training in dreamwork and use of dreamwork techniques in therapy support previous findings of Keller et al. and Schredl et al., who also found a relationship between training and the use of dreams in therapy. This study went further to explore the specific types of dream activities used in therapy, what type of clients or situations would dreamwork be employed, and how therapists' training, attitudes, beliefs, and personal dreamwork activities influenced the amount of dreamwork utilized.

Crook and Hill's (2003) survey was replicated by Hill, Liu, Spangler, Sim, and Schottenbauer (2008) who surveyed 47 attendees of a *Dreams in Psychotherapy: An Integrative Approach* day-long workshop. Hill et al. (2008) used the same survey, *Therapist Dream Questionnaire* (Crook & Hill, 2003). The researchers noted that the participants were not primarily cognitive-behavioral in orientation, and they reported some interesting differences from the previous study. These respondents, all psychoanalytic therapists, reported feeling competent about working with dreams in therapy, and they had had more training related to clinical dreamwork. Hill et al. found the most frequent dream activities were "listen if a client brings in dreams" (*M* = 4.81; *SD* = 0.50) and "encourage client to associate to dream images" (*M* = 4.49; *SD* = 1.02). Because they conducted this survey during a training workshop on dreams with a small sample and with only a single theoretical orientation, these results cannot be generalized to other psychotherapists. This survey did illuminate some of the differences between psychodynamic therapists and cognitive-behavioral therapists.

The previous research that explored how therapists used dreams in therapy provided a basic understanding of the frequency of dreamwork, the theoretical underpinnings of modern

dreamwork, and therapists' attitudes and personal dreamwork activities. The surveys point to the importance of training in dreamwork and explore how different theoretical orientations approach dreams in therapy. It is inadvisable to assume that these surveys portray the only uses of dreams in therapy. Expressive arts therapists, art therapists, and music therapists also use dreams and imagery to facilitate therapeutic change (Atkins et al., 2003; Davis, 1995; Priestley, 1994; Wärja, 1994).

The Bonny Method of Guided Imagery and Music

One form of psychotherapy that emphasizes imagery is GIM. Music therapists, counselors, psychologists, and other professionals in the mental health field who have completed specific training in GIM facilitate sessions. Both clinical dreamwork and GIM use imagery to facilitate client insight (Bush, 1988; Clarkson, 2002; Clark, 2002; Eudell-Simmons & Hilsenroth, 2007). The Association for Music and Imagery (2010) defined GIM as, "…a music-assisted integrative therapy which facilitates explorations of consciousness that can lead to transformation and wholeness" (p. 3).

Helen Bonny developed GIM in the early 1970s while working at the Maryland Psychiatric Research Center (Lewis, 2002). Researchers at the Center began looking at the effects of lysergic acid diethylamide (LSD) on the psyche. The researchers had found that music was successful as a guide, to a degree, when used in conjunction with LSD, though they were unscientific in their approach (Bonny, 2002a, p. 47). They employed Bonny, a registered music therapist, to assist in selecting the music for the sessions. She began exploring various programs of music to provide hours of audio for the 12-hour LSD "trip" (Bonny & Pahnke, 1972/2002). From 600 sessions with a wide range of clients (from colleagues to adults with substance abuse disorders) Bonny and Pahnke found that music

contributed to the LSD experience "by helping the client relinquish usual controls and enter more fully into his inner world of experience, by facilitating the release of intense emotionality, by contributing toward a peak experience, by providing continuity in an experience of timelessness, and by directing and structuring the experience" (Bonny, 2002, p. 47). Bonny began using music and relaxation with spouses of clients receiving LSD, who often had to wait for long periods of time. She found that the spouses or friends often had vivid imagery with music alone. Additionally, the spouse was able to easily recall images from the trip while the client could not due to the amnesic effects of LSD. Following this work with music and imagery, Bonny began condensing music programs from hours in length down to approximately 40 minutes and used all classical selections, which is how they remain today. During the next 20 years, the Bonny Method began to emerge as a form of music psychotherapy.

The session structure of GIM. A typical GIM session consists of "the prelude" or preliminary conversation followed by the relaxation induction; the music; and finally the "postlude" or "integration" (Grocke, 2005, pp. 46-47). Ventre (2002) further described the process, which begins with an intake interview at the initial session. This interview includes a description of what to expect in the session and client history, including experiences with altered states of consciousness. Often this intake interview occurs with the initial music and imagery session as part of the preliminary conversation. The preliminary conversation, lasting approximately 20-30 minutes, is the time for a verbal check-in; here the therapist and the client begin their relationship. The therapist listens for what issues that may arise in the music and chooses a program of classical pieces to fit the client's particular needs. Next is an induction; the length varies and is typically at least 10 minutes. This may be a time of

physical relaxation, and the purpose is to shift focus and move to an altered state of consciousness. The main part of the session is the music listening, approximately 40 minutes in length. Bonny viewed the music and imagery itself as the therapy. The clients, called travelers, report what they experience as they listen to the music. The primary roles of the GIM therapist, or guide, are to support the traveler during the experience and encourage him or her to fully engage with the images. The guide maintains verbal contact and follows the traveler through the music. One reason for extensive training of the guides is for them to develop a deeper understanding of each piece of music in order to effectively use the music to inspire imagery. The session concludes with a postlude of approximately 30 minutes. During this time the guide assists the traveler in "returning to a more externally oriented state" (Ventre, 2002, p. 33). The GIM therapist often uses creative modalities, such as mandalas, to bridge the imagery experience to the verbal processing and to further re-orient the traveler (Bonny & Kellogg, 1977/2002; Bush, 1988). The guide and traveler then process the experience verbally. A main aspect of the verbal processing is that the traveler directs it; the guide supports and offers feedback when asked by the traveler. GIM therapy may consist of as few as three sessions or as many as 20 or more; a typical length of a series is ten sessions.

A key component of GIM therapy is working in altered states of consciousness. Bonny (1975/2002b) described a cut-log view of consciousness, with ego being in the center and expanding outward through various states including "study," "day-dreams," "prayer," "dreams," "imagination," "creativity," and the outer-most layer, "collective unconsciousness" (p. 82). Dreaming is an altered state of consciousness, as is relaxation. Bonny discovered that the relaxation induction's primary purpose and reason it was

successful in early GIM was to induce an altered state of consciousness. Bonny coupled the relaxation induction with music because of the varied elements found in music; “The movement of music, the rise and fall of dynamics brings about a wide sweep of those levels or layers of consciousness . . . .” (p. 86). Working with altered states of consciousness and the psyche, a sensitive process, is one reason for the requirement of rigorous training in order to successfully and ethically facilitate GIM.

Imagery, another main component in GIM, is varied and includes experiences beyond visual representations. GIM therapists define imagery broadly as any experience during the music and listening. Imagery may be experienced as visual, auditory, olfactory, physical (including kinesthetic and tactile sensations), or emotional sensation (Bonny, 1975/2002b); it might also be symbolized by a reaction to the music, to the environment, or to the traveler’s own thought process. Bush (1995) described several different types of “imagers” (p. 50) or types of travelers. Imagery may be experienced during GIM as an implication of something there, or as Bush described, an “intuitive imager.” This traveler may have the sense that something is occurring but not experience a vivid visual image. Another type of imager is a “sensate imager” (p. 51); these travelers may experience kinesthetic and physical imagery, including when experiencing emotional imagery. The sensate imager may experience emotion through a bodily sensation, such as “knots in the stomach” (p. 51). The third type of imager is the “visualizer,” and as the name implies, this traveler tends to see visual imagery as the primary form of imagery. Summer (1988) described four levels of imagery, each corresponding to different types of imagery experiences. She described the first level as the “abstract/ aesthetic level”; this level may be experienced with predominantly visual and kinesthetic imagery and perhaps a “deep enjoyment of the music” (p. 27). The second level is

psychodynamic experiences, characterized by "literal, repressed memories; experiences of conflicts (especially interpersonal); and insights regarding aspects of one's life as symbolized in the imagery" (p. 28). Summer described the third level of imagery, the perinatal, as "somatic and existential experiences" (p. 29). The fourth level of imagery is the transpersonal level, typically experienced as a peak experience, a time when "imagery loses its ordinary personal meaning and acquires a symbology of the universal, collective unconscious mind" (pp. 29–30). Extensive training and supervision is essential for understanding the variety of imagery experiences and altered states of consciousness that occur during GIM.

Training for GIM therapists consists of three levels and varies in scope depending on the individual primary trainer. GIM training emphasizes the historical foundations of GIM, methods for relaxation inductions, contraindications, guiding techniques, music analysis, and may include other modalities such as mandalas, body-centered techniques, and dreamwork. Required texts and readings are comprehensive in the field of GIM and include much of the research in GIM; all training programs require readings from "relevant psychological theories, counseling skills, psychopathology, transpersonal concepts, concepts of music, concepts of imagery, and symbology" (Association for Music and Imagery, 2010, p. 12). Some training programs require additional literature from grief counseling, dreamwork, consciousness, ethics, integral psychology, and abuse or trauma (McKinney, 2011). Individuals who have completed a 3- to 4-year postgraduate training program are designated as Fellows of the Association for Music and Imagery (Association for Music and Imagery, 2011).

Clinical Dreamwork in GIM

GIM therapists may elicit dreams during the preliminary conversation as this is the time when the therapist gathers information about the client's life and experiences. Grocke (2005) stated that when dreams are brought to light during the preliminary conversation, "the content of the dream is then discussed, and a focus image may emerge from the dream material" (p. 46). This is one way the GIM therapist may bring dreams into the GIM session and work with them in the context of the music. Bush (1988) used dreamwork in a GIM case study along with MARI cards and mandalas to further access the client's unconscious material. Bush also used dreams that occurred during the treatment period to assess client progress and to indicate areas of growth and need.

Abbott (2007-2008) described the preliminary conversation as a time in which the therapist may "encourage the client to participate in creative arts experiences designed to access therapeutic issues" (p. 2). Atkins et al. (2003) included dreamwork as a component of expressive arts therapy. Although Abbott does not directly cite working with dreams in the preliminary conversation, as Grocke (2005) mentioned, this is the time in the session that most initial dreamwork would occur. There are few reports of using dream content in the GIM session, although anecdotal evidence suggests many GIM therapists inquire about client dreams at some point in the GIM process.

One of the main training texts for GIM is *Guided Imagery and Music: The Bonny Method and Beyond* (Bruscia & Grocke, 2002). This resource features two chapters that directly address dreamwork and GIM. Meadows (2002) made the distinction between GIM and Jung's dream analysis/active imagination (p. 66). Meadows described Jung's approach to dreamwork as "according to his own understanding of the psyche…" (p. 66). Meadows

compared GIM to Jung's dream analysis by pointing out the similarities in the methods: both value the client's imagery experience and the "affective experiences of the imagery" (p. 67). He directly related the differences between these approaches to the therapist's role. In another chapter, Clarkson (2002) provided evidence of combining Gestalt dreamwork with GIM. Clarkson described GIM sessions as "often called 'waking dreams,' so dreamwork has a natural and safe home with this form of transpersonal music-centered therapy" (p. 248). Clarkson provided two case studies that displayed different ways of using Gestalt principles within the GIM session. These two case studies provide ideas for beginning to incorporate Gestalt dreamwork into GIM sessions.

The field of GIM is growing and adapting to meet current mental health needs (Lin et al., 2010; Powell, 2007–2008; Summer, 1988; Trondalen, 2009–2010). Dreamwork couples nicely with GIM in that they both center on working with imagery in a therapeutic manner (Clarkson, 2002). There are several examples of GIM case studies in which dreams were used successfully, enhancing the therapeutic outcomes (Bush, 1988). Despite having two chapters that describe cases of using dreamwork with GIM, there is no protocol or formal method put forth for GIM therapists who wish to incorporate dreamwork into their practice. Additionally, the only mention of dreams in the *Manual of Standards and Procedures for Endorsement of the Bonny Method of GIM Trainers and Training Programs* (Association for Music and Imagery, 2010) is in reference to alternative states of consciousness (p. 4). A survey of GIM therapists' use of dreamwork has not been previously conducted.

Research Questions and Hypotheses

The purpose of this study was to examine the use of, training for, and therapist attitudes toward clinical dreamwork in conjunction with GIM sessions. The researcher

hypothesized that many GIM therapists will report using dreamwork in sessions but that there will be wide variance in training related to clinical dreamwork. The researcher also hypothesized that therapists who report personal dreamwork and positive attitudes toward dreamwork will use dreams in GIM sessions more frequently.

CHAPTER 2

METHOD

This chapter will describe how the study was conducted. This will include a description of the respondents for the study, the development of the survey instrument, the design, the procedure, and how the data was analyzed.

Respondents

The researcher solicited respondents via e-mail (see Appendix A) from 266 Fellows and advanced trainees who are current members of the Association of Music and Imagery and the Music and Imagery Association of Australia. Two association members were excluded due to direct involvement with the research study and the email address was not available for one additional association member. Of the 266 e-mails sent, 10 were undeliverable, 4 respondents sent e-mail messages indicating that they were no longer providing GIM sessions, and 2 respondents e-mailed to decline participation. Out of a total of 250 potential respondents, 61 questionnaires were submitted, resulting in a response rate of 24%.

The 61 respondents, 51 females and 10 males, represented 19 different countries: 53% from the United States; 8% from Australia; 5% from Canada; 5% from Spain; 3% from Denmark; 3% from Mexico; 3% from Sweden; and 20% (1 each) from the countries of Bulgaria, China, Estonia, Germany, Greece, Iceland, Italy, Japan, Norway, South Africa, Switzerland, and the United Kingdom. The average age of respondents was 53.36 (*SD* =

11.72). Respondents reported an average of 11.38 years (*SD* = 8.43) of experience facilitating GIM sessions and providing GIM sessions for an average of 4.00 hours per week (*SD* = 2.68). The respondents worked in multiple settings with the majority reporting working in private practice (74%). Other work settings included agency/hospital/hospice (18%), university/academic (30%), and schools (2%). Of the 61 respondents, 85% had completed all levels of training in GIM; 15% of respondents were Advanced Trainees. Respondents reported the highest degree earned and 66% hold a Masters degree, 32% hold a Doctorate degree, and 3% hold a Bachelors degree or are current graduate students.

Instrument

The author adapted the *Therapist Dream Questionnaire* (Crook & Hill, 2003) to create the *Dreamwork with Guided Imagery and Music Questionnaire* (Appendix A) in order to examine clinical dream work training, methods employed by GIM therapists, clients who GIM therapists use dreamwork with, and GIM therapist's attitudes toward dreams. The questionnaire was available to respondents in English only through GoogleDocs. The survey consisted of five sections (Appendix A). Section One inquired about the demographic features of the GIM therapist including age, country where practicing, educational level, and level of training in GIM. Section Two collected data about years of practice in GIM, education in clinical dreamwork, percentage of GIM clients who brought dreams to therapy, and time spent weekly in GIM sessions. This section also included questions relating to the theoretical orientation of the therapist and how competent the therapist felt doing dreamwork. Section Three had 35 items that used 5-point Likert scales (1 = *never*; 5 = *frequently*) to assess the frequency and type of activities that therapists used when working with dreams

during different sections of a GIM session (the prelude; the induction, focus image, and music; and the postlude).

Section Four explored the GIM therapist's attitudes and personal experience with clinical dreamwork. Again, 5-point Likert scales were used (1 = *Strongly disagree*; 5 = *Strongly agree*). Sample prompts were: "Dreams represent unconscious messages" or "Dreams reflect waking life." This section also included multiple choice questions that inquired about the therapist's dream recall and dream frequency. Section Five was two open-ended questions that invited additional thoughts about working with dreams in GIM. The second question was optional and was a prompt to share an example of using dreams in GIM from the therapist's personal experience in therapy.

Design

The study used a mixed methods design to provide a broader picture of how dreamwork is and can be used in GIM sessions. The quantitative data provided descriptive data of current practices with therapist's training and attitudes. The qualitative data consisted of themes from the three open-ended prompts that illustrate ways to implement dreamwork within Guided Imagery and Music sessions and respondent's personal examples of dreamwork in GIM.

Procedure

Because of the small number of current practitioners of GIM, all current members of AMI who were listed as Fellows of the Association or Level III Trainees and several therapists who were members of the Music and Imagery Association of Australia were potential respondents. Data were gathered electronically by two e-mails with the link to the

questionnaire: one with the original request and a deadline for submission 4 weeks away and a second one 2 weeks prior to the final date for data collection.

Data Analysis

Quantitative data were analyzed using Statistical Package for Social Sciences, version 19. Descriptive statistics and bivariate, one-tailed Pearson's correlations were computed with the variables of therapists' beliefs, attitudes, and personal dreamwork and frequency of dream activities in GIM sessions. Qualitative data were analyzed by examining responses and determining themes based on three open-ended questions from the *Dreamwork with Guided Imagery and Music Questionnaire*.

CHAPTER 3

QUANTITATIVE RESULTS

This section will report the quantitative results from 91 items of the *Dreamwork with Guided Imagery and Music Questionnaire.* Descriptive statistics are provided for items that describe the amount of clients seen for GIM, type of clients who may work with dreams, therapist attitudes, beliefs, and personal dreamwork activities, and frequency of using dream activities in the preliminary conversation, induction, focus image, and music, and postlude. Correlations between therapists' dream attitudes, beliefs, and personal dreamwork activities and frequency of using dream activities in GIM are shown.

Therapeutic Practices and Training

Respondents reported working with dreams in GIM an average of 21.61% of the time (*SD* = 16.88) and reported 43.58% of GIM clients brought dreams into sessions during the past year (*SD* = 30.45). Respondents rated their adherence to three psychotherapy theories: 85.2% reported high adherence to humanistic/existential theories, 70.9% reported high adherence to psychoanalytic/psychodynamic theory, and 13.2% reported high adherence to behavioral/cognitive-behavioral theories (high adherence were ratings of 4 or 5 on Likert scale where 1 = *low*, 5 = *high*).

In regards to training and feeling competent in dream interpretation or dreamwork, 38% of the respondents reported little to no training, 26% reported moderate training, and 28% reported higher to extensive training. Out of those who reported having had training,

100% responded with examples of their dreamwork training: 82% of reported learning dreamwork from "reading," 72% attended a dreamwork "workshop/seminar," 58% reported receiving dreamwork training during "supervision," 26% had training in dreamwork through "graduate courses," 16% learned dreamwork methods by working with their own dreams, and 6% of the respondents reported dreamwork training through Jungian psychoanalysis training or Gestalt training. The mean rating (1 = *not at all competent*, 5 = *extremely competent*) of competence in dreamwork was 3.16 (*SD* = 1.13), indicating that most respondents felt moderately competent working with dreams. Respondents also rated how important they thought it is to work with dreams in therapy. The mean rating (1 = *not important*, 5 = *very important)* was 4.00 (*SD* = 0.93) indicating most GIM therapists think that working with dreams in therapy is important.

Respondents rated their likelihood to work with various clients and types of dreams (see Table 1). The highest likelihood for using dreams in the GIM session were "healthy client seeking growth" and "client presents recurrent dream." GIM therapists were less likely to work with dreams with clients who were not psychologically minded or clients who were diagnosed with a personality disorder. Respondents also reported that dreamwork was moderately used during long-term therapy, when there would be plenty of time to explore dreams.

Table 1

Ratings of Likelihood to Work With Dreams in Various Situations and With Various Clients

	M	*SD*
Healthy client seeking growth	**4.57**	0.86
Client presents recurrent dreams	**4.53**	0.85
Client is interested in learning about his/her dreams	**4.44**	0.87
Client presents troubling dreams or nightmares	**4.17**	1.12
Client is willing to work with dreams	**4.11**	1.03
Psychologically-minded client	**4.00**	1.21
Client with depression/anxiety	**3.93**	1.13
Client presents a pleasant dream	**3.67**	1.15
Clients with recurrent nightmares	**3.66**	1.21
Client with adjustment disorder	**3.57**	1.28
We are at an impasse in therapy or "stuck"	3.44	1.34
Client with substance abuse problem	3.41	1.20
Client with Post-Traumatic Stress Disorder (PTSD)	3.31	1.29
Client presents a dream as a way of avoiding important life issues	3.00	1.30
Not psychologically-minded client	2.84	1.18
Have plenty of time in long-term therapy	2.76	1.64
Client with personality disorder	2.55	1.24

Note. N = 51-54. Ratings based on 5-point scale (1 = *not likely*; 5 = *very likely*). Means > 3.5 = high likelihood, means < 3.49 and > 2.5 = moderate likelihood, and means < 2.49 = low likelihood

Dream Activities During the GIM Session

Three main sections of the GIM session were examined for what types of dream activities are used. Respondents reported the use of dream activities during the preliminary conversation; the induction, focus image, and music; and the postlude.

Preliminary conversation. Dream activities during the preliminary conversation are shown in Table 2. The respondents reported the highest frequency of dream activities during the preliminary conversation. The highest rated dream activities during the preliminary

conversation were “listen if a client brings in a dream” and “ask client to describe images in greater detail.” The least often dream activities to occur during the preliminary conversation were “interpret dream according to unconscious wishes” and “help client try to change the dream.”

Table 2

Dream Activities During the Preliminary Conversation

	M	*SD*
Listen if a client brings in a dream	**4.69**	0.72
Ask client to describe images in greater detail	**4.20**	1.08
Work with conflicts that are represented in dreams	**3.56**	1.24
Use dream images as metaphors later in therapy	**3.56**	1.17
Relate the dream to client’s current waking life experience	**3.51**	1.28
Encourage client to associate to dream images	3.47	1.46
Collaborate with client to construct a meaning of the dream	3.44	1.27
Invite clients to tell a dream	3.22	1.24
Relate the dream to client’s past experiences	3.22	1.27
Ask client for triggers in waking life to dream images	2.94	1.39
Mention that you are willing to work with dreams	2.75	1.38
Relate dream to spiritual beliefs	2.46	1.08
Interpret dream according to archetypes	2.30	1.08
Explain how you work with dreams	2.27	1.30
Interpret dream in terms of the therapy relationship	2.24	1.25
Ask client to act out different parts of the dream	2.00	1.17
Interpret dream according to unconscious wishes	1.87	1.05
Help client try to change the dream	1.58	0.96

Note. N = 54-56. Ratings based on 5-point scale (1 = *never*; 5 = *frequently*). Means > 3.5 = high frequency, means < 3.49 and > 2.5 = moderate frequency, and means < 2.49 = low frequency

Induction, focus image, and music. Table 3 shows dream activities during the induction, focus image, and music section of the GIM session. During this section the most commonly used dream activities were "use dream images as metaphors later in therapy" and "use a dream as the focus image." The least frequent dream activity during this section was "encourage client to re-experience feelings from a dream."

Table 3

Dream Activities During the Induction, Focus Image, or Music

	M	*SD*
Use dream images as metaphors later in therapy	**3.54**	1.22
Use a dream image as the focus image	3.42	1.32
Use the dream themes or feelings to determine the music program	3.38	1.34
Use dream feeling as the focus image	3.37	1.43
Work with conflicts that are represented in dreams	3.13	1.31
Encourage client to re-experience feelings from a dream	2.96	1.39

Note. N = 54-55. Ratings based on 5-point scale (1 = *never*; 5 = *frequently)*. Means > 3.5 = high frequency, means < 3.49 and > 2.5 = moderate frequency, and means < 2.49 = low frequency

Postlude. The frequency and type of postlude dream activities are shown in Table 4. The highest frequency dream activity was "collaborate with client to construct a meaning of the dream." It is interesting to note that the items "interpret dream according to unconscious wishes," "give client your understanding of what the dream means," and "suggest to client what changes s/he could make based on learnings from the dream" were all rated a mean of less than two, indicating that those activities occur the least often.

Table 4

Dream Activities During the Postlude

	M	*SD*
Collaborate with client to construct a meaning of the dream	**3.53**	1.33
Compare the dream images with the GIM imagery experience	3.40	1.23
Relate the dream to client's current waking life	3.27	1.31
Relate the dream to past experiences in client's life	3.05	1.31
Work with client to develop ideas for making changes based on what s/he learned in the dream	3.04	1.39
Relate dream to spiritual beliefs	2.43	1.14
Interpret dream according to archetypes	2.20	1.04
Interpret the dream in terms of the therapy relationship	2.11	1.16
Suggest to client what changes s/he could make based on learnings from the dream	1.93	1.03
Interpret dream according to unconscious wishes	1.89	1.13
Give client your understanding of what the dream means	1.76	0.92

Note. N = 53-55. Ratings based on 5-point scale (1 = *never*; 5 = *frequently*). Means > 3.5 = high frequency, means < 3.49 and > 2.5 = moderate frequency, and means < 2.49 = low frequency

GIM Therapist Attitudes, Beliefs, and Personal Dreamwork

GIM therapists were asked to rate their own beliefs and attitudes regarding dreamwork (see Table 5). The highest rated attitudes and beliefs were "dreams have meaning" and "I value my dreams." Conversely, the lowest rated attitudes and beliefs were "dreams are meaningless" and "I do not pay attention to my own dreams." In addition, the respondents rated dream activities that they engaged in (see Table 6). The highest rated activity was, "try to figure out dream on your own." In the past two weeks, 50.0% of the respondents reported recalling dreams every morning to most mornings. Only 5.4% of respondents reported not recalling a single dream during the previous two weeks. In regards to the respondents general recollection of dreams, 32.1% reported remembering dreams two

to three times a week; 28.6% recalled dreams almost once a week; 19.6% recalled dreams about every night; 17.9% recalled dreams one to two times a month; and 3.6% recalled dreams less than once a month. Respondents also reported working with dreams in therapy. The majority of respondents (73.2%) reported working with dreams in their own therapy "some" to "often."

Table 5

Guided Imagery and Music Therapist's Beliefs and Attitudes About Dreams

	M	*SD*
Dreams have meaning	**4.62**	0.56
I value my dreams	**4.55**	0.82
Dreams represent unconscious messages	**4.50**	0.82
Dreams are attempts at problem solving	**4.04**	0.84
Dreams reflect waking life	**4.00**	0.99
I believe that dreams are one of the most important ways to understand myself	**3.83**	1.13
Dreams are due to random firings in the brain	1.90	0.96
Dreams are messages from external sources (i.e., God, devil, deceased relatives)	1.89	1.11
Dreams represent the brain's attempt to purge unneeded connections	1.79	0.89
I dislike speculation about the meaning of dreams	1.62	0.99
Practical everyday life is too important to me to pay attention to my dreams	1.50	1.01
Dreams are too confusing to have any meaning to me	1.28	0.64
Dreams are meaningless	1.22	0.66
I do not pay attention to my own dreams	1.21	0.59

Note. N = 52-55. Ratings based on 5-point scale (1 = *strongly disagree*; 5 = *strongly agree*). Means > 3.5 = high agreement, means < 3.49 and > 2.5 = moderate agreement, and means < 2.49 = low or no agreement

Table 6

Guided Imagery and Music Therapist's Dream Activities

	M	*SD*
Try to figure out dream on your own	**4.07**	1.07
Talk about salient dreams with a colleague, friend, partner, or therapist	**3.88**	1.09
Keep a dream journal	2.54	1.39

Note. N = 55-58. Ratings based on 5-point scale (1 = *never*; 5 = *frequently*). Means > 3.5 = high frequency, means < 3.49 and > 2.5 = moderate frequency, and means < 2.49 = low frequency

GIM Therapist Training, Competence, and Importance of Dreams

The relationship between the amount of dream training, therapist competence working with dreams, and therapist rating of the importance of working with dreams in therapy is shown in Table 7. Therapists who had more training felt more confident working with dreams. Additionally, therapists with more dream training highly valued the importance of working with dreams.

Table 7

Pearson Correlation Coefficients Between Guided Imagery and Music Therapist Training, Feeling Competent, and Importance of Dreams

	Therapist ratings of competence working with dreams	Therapist rating of importance of working with dreams in therapy
Amount of training in dream interpretation	0.82**	0.33**
Therapist ratings of competence working with dreams		0.28*

Note. *Correlation is significant at the 0.05 level (1-tailed).
**Correlation is significant at the 0.01 level (1-tailed).

Relationship Between GIM Therapist Attitudes and Frequency of Dream Activities

Correlations between therapists' beliefs, attitudes, and personal dream activities and their frequency of using specific dream activities were also found. Table 8 shows significant correlations between therapists' beliefs, attitudes, and personal dreamwork and their use of dreamwork during the preliminary conversation. Table 9 displays the significant correlations between therapists' beliefs, attitudes, and personal dreamwork and their use of dreamwork in the induction, focus image, and music. Table 10 shows the significant correlations between therapists' beliefs, attitudes, and personal dreamwork and their use of dreamwork in the postlude.

Table 8

Pearson Correlation Coefficients Between Guided Imagery and Music Therapist's Beliefs, Attitudes, and Personal Dreamwork and Their Use of Dream Activities During the Preliminary Conversation

	Listen if a client brings in a dream	Work with conflicts that are represented in dreams	Use dream images as metaphors later in therapy	Relate the dream to client's current waking life	Collaborate with client to construct a meaning of the dream	Invite clients to tell a dream	Mention that you are willing to work with dreams	Explain how you work with dreams
Dreams have meaning	0.39**		0.25*	0.25*	0.34**	0.26*		
I value my dreams	0.44**	0.32*	0.34**	0.31*	0.33**	0.38**	0.39**	0.37**
Dreams reflect waking life	0.35**	0.36**		0.27*	0.28*	0.31*		
I believe that dreams are one of the most important ways to understand myself	0.24*					0.42**	0.43**	0.36**
I do not pay attention to my own dreams	-0.70**	-0.29*	-0.26*	-0.32**	-0.32**	-0.31**	-0.31**	-0.25*
Therapist's rating of frequency of working with own dreams in therapy		0.24*	0.23*	0.36**		0.29*	0.24*	0.39**
Therapist tries to figure out dream on his/her own	0.43**	0.37**	0.26*	0.38**	0.33**	0.29*		
Therapist keeps a dream journal		0.26*		0.29*	0.24*	0.36**		

Note. *Correlation is significant at the 0.05 level (1-tailed). **Correlation is significant at the 0.01 level (1-tailed).

Table 9

Pearson Correlation Coefficients Between Guided Imagery and Music Therapist's Beliefs, Attitudes, and Personal Dreamwork and Their Use of Dream Activities During the Induction, Focus Image, and Music

	Use dream images as metaphors later in therapy	Use a dream as the focus image	Use the dream themes/ feelings to determine the music program	Work with conflicts that are represented in dreams	Encourage client to re-experience feelings from a dream
I value my dreams	0.41**	0.26*	0.34**	0.29*	0.29*
Dreams reflect waking life	0.32*				0.33**
I do not pay attention to my own dreams	-0.32**		-0.31**		
Therapist's rating of frequency of working with own dreams in therapy	0.33**	0.24*	0.45*	0.23*	0.25*
Try to figure out dream on your own	0.25*		0.23*		0.27*

Note. *Correlation is significant at the 0.05 level (1-tailed).
**Correlation is significant at the 0.01 level (1-tailed).

Table 10

Pearson Correlation Coefficients Between Guided Imagery and Music Therapist's Beliefs, Attitudes, and Personal Dreamwork and Their Use of Dream Activities During the Postlude

	Collaborate with client to construct a meaning of the dream	Compare the dream images with the GIM imagery experience	Relate the dream to client's current waking life	Relate the dream to past experiences in client's life	Interpret dream according to archetypes	Relate dream to spiritual beliefs
Dreams have meaning	0.30*	0.24*	0.40**	0.41**		0.25*
I value my dreams	0.37**	0.29*	0.42**	0.29*	0.26*	0.23*
I do not pay attention to my own dreams	-0.26*		-0.27*		-0.25*	
Therapist's rating of frequency of working with own dreams in therapy			0.24*	0.25*	0.29*	0.34**
Try to figure out dream on your own			0.24*	0.28*	0.27*	

Note. *Correlation is significant at the 0.05 level (1-tailed).
**Correlation is significant at the 0.01 level (1-tailed).

CHAPTER 4

QUALITATIVE RESULTS

Respondents were asked three open-ended questions related to their experience with GIM and dreamwork. This chapter includes a description of other factors that lead to working with dreams in GIM and personal reflections about using dreams with GIM. Respondents' dreams and opinions are provided as further evidence of how dreams are used in GIM therapy and several outcomes of working with dreams and GIM. For a listing of additional responses not included in this section, see Appendix C.

Other Factors that Lead to Dreamwork Within GIM

Respondents reported other factors, situations, or circumstances for working with dreams in GIM. Responses were divided into three themes: client-initiated or client-directed, the process of therapy, and therapist training. The responses ranged from two words to several sentences. By far the greatest factor for working with dreams in the GIM session was based on the client's need or desire.

Client-initiated or client-directed. Of the 30 responses to this prompt, 60% reported that if a client brought in a dream, requested working on a dream, or recalled a specific dream then the GIM therapist would work with the dream. This emphasizes the client-centered nature of GIM work. Specific factors, situations, and circumstances related to a client-centered approach that were in the questionnaire include, "If a client brings a dream, I will always work on it," "if this is something in which the client places great value in his/her life," "client seeking answers to specific existential life situations," "client dreams of

someone who they lost in life, who is deceased," and "client is not very verbal but willing to talk about a dream." Many respondents stressed that dreams would be addressed in the GIM session only when a client initiated or requested it.

Process of therapy. Other factors for working with dreams included how the dream was used within the process of GIM therapy. One respondent reported that dreamwork may occur in the GIM session when "art work…brings in dream images," which is consistent with an intermodal approach used by many GIM therapists. Several respondents indicated that the initial session or beginning of therapy was a factor in working with dreams, for example, "It seems to stir up the dream life so I especially ask about dreams at the beginning of therapy." Other respondents cited instances when dreamwork may address specific goals of therapy, including "to gain greater insight," "if a dream evokes strong emotion or a memory," and "[when] unresolved issues continue to manifest in the dream and in regular GIM sessions." Another example of using dreams during the process of therapy is "the opportunity to dialogue with characters, or figures in the dream—either in the prelude, the music and imagery segment, or in the postlude."

Therapist training. Several respondents reported that training was a factor when deciding to work with dreams in GIM sessions. One respondent reported, "More training/knowledge would mean I would invite it more from my clients." These responses are consistent with the correlations among therapist's ratings of training, competence, and the importance of dreams in therapy.

Thoughts about Working with Dreams

When asked to share their thoughts and opinions about working with dreams within GIM sessions, 31 respondents submitted responses. These responses have been sorted based

on two categories: content that related to dreamwork within GIM and content that expressed therapist experiences and values.

Dreamwork within GIM. Several respondents referred to training in dreamwork and the desire for additional training: "I don't feel like I have enough training in this area…more training on integrating dreamwork into GIM practice would be welcome." Many of the respondents referred to how they use dream images in the GIM session within various sections of the session. The following are several examples of these responses related to using dreams:

- They can be powerful when used as focus image.
- …It is not uncommon for a client to come in and say they had a dream the night before a session. If they bring in a dream, it is usually not surprising and it fits with exactly what we are working on. . . .We may interpret the dream, or we may use it as a prelude. To me, interpreting the dream or the travel is very much the same thing. We always give the client a way to work on the dream and travel information in life.
- I find when a client brings in a dream it can be very helpful to inform my choice of music, induction, and focus image. They are often direct communications from the unconscious just like GIM material.
- Using dreams as inductions has been useful to break through conflicts or blocks, and helped clients gain new insights.

Other responses compared the GIM imagery to dream images and shared how dreams enhanced or could be an indication of the therapeutic process.

- Any process that increases the narrative of the dream is beneficial. GIM and dreaming have so much in common in that they both present strong images that reflect the life of the dreamer/traveler that it would be failing the client not to use them.
- I find some clients often have significant dreams a day or two before a GIM session and come VERY prepared to work with presenting issues.
- I often explain GIM as a similar process to dreaming while awake and point out that GIM allows time to stay with images and to interact with them.
- If they don't come up, I don't bring them up.
- Clients usually report a change in the frequency and quality of their dreams as they progress through a longer (at least 12) series of GIM sessions.

Respondents also pointed to using dreams to build rapport and trust. Several respondents drew comparisons between metaphors in dreams and the GIM imagery: "I believe we tap a similar metaphoric world. Dreams can be deeper, more symbolic." One respondent pointed out that the therapeutic community in his/her country tended to endorse a cognitive orientation to psychotherapy and considers dreamwork old fashioned. Of the respondents who endorsed the use of dreamwork within GIM, one unifying thread was the link between dream images and the metaphors and images that emerge from the GIM session.

Therapist experiences and values. Respondents shared their personal experiences and values surrounding working with dreams in the GIM session. Many respondents cited the importance of dreams in their own lives and when used with GIM.

- I believe dreams are very powerful inner processes as we seek to reconcile situations in life that are problematic, or difficult to grasp.
- I personally feel bereft if I go too long without a dream—they're that important. But sometimes the outer world dominates. While I think GIM is terrifically important, content of GIM sessions may be influenced by the music. The dream itself is the raw material.
- I keep a dream journal and work with my dreams both on my own and with my partner. This has been an important piece of my life for more than 10 years and aids in my on-going connection with my inner world.
- I value [all] information that the client brings to the GIM session. My opinion is that dreams have no special value among any other experiences, thoughts, feelings, insights, etc…I don't especially encourage the client to bring them in and I focus more on GIM images laden by actual material from the current session, including material from dreams if appropriate.
- I believe dreams can be continued through GIM and also GIM sessions can be continued through dreams—and often are.

Respondents described their theoretical orientation and how dreamwork related to their own style of therapy. One respondent emphasized using other creative arts and the importance of body-centered work. Another respondent was curious about exploring GIM and dreamwork with the Jungian community. One respondent discussed working as a humanistic psychotherapist and described a holistic approach, "between body and mind, soul and spirit, emotions and thoughts" for working with dreams in GIM.

Examples of Dreamwork with GIM

The final prompt requested a personal example of dreamwork in GIM. Respondents (n = 13) submitted dreams that were used in or related to work in GIM, client examples, and other comments related to the survey. This section provides personal accounts of the profound outcomes when exploring dreams in conjunction with on-going GIM work.

Personal dreamwork in GIM. Respondents provided rich narratives of dream content, therapeutic process, and outcomes. Several reported dreams they had during their advanced training in GIM. Below are two examples of these responses:

- During my GIM training I worked through a lot of grief and loss from my childhood. Towards the end of my personal sessions I had a dream that I was stuck on the side of a wall near a railway station. I was carrying a camera, which I dropped down the side of the wall…. The dream was a puzzle to me and we took it into a GIM session. During the session an image of two swans came to me. The white swan was confident and flew high, but the black swan was stuck, curled up on the side of the river bank. The white swan helped the black swan to stand and stretch her feathers. Then I had a memory of being depressed as an adolescent. It was never acknowledged and I learned to 'cope' with life by using stoicism. GIM and the dream reminded me that there is a part of myself (the creative part) that needs nurturing.
- During my advanced GIM training I dreamt I was one kitten in a litter with my other classmates, all snuggled together, safe, warm, content. I was the only one of the group who travelled a large distance to attend trainings, and often felt disconnected. This dream affirmed my belonging as one of the group who both

> rested my head and was a head rest for others. I took this image to my next personal GIM session.

These examples show how dream images are often transformed into other images during the GIM session. New awareness, perspectives, and memories may be illuminated through the use of dream images in GIM.

Respondents also shared dreams that were important in their lives, not necessarily related directly to GIM work. The example below shows how the therapist developed personal insights as a result of dreamwork. Additionally, this example shows the importance of taking action following dreamwork.

> There are many dreams that have guided me into taking positive action for my own sake and for the sake of others. In January last year my elderly brother in law was involved in a car accident and while he was not physically injured, it was clear to the police that he was very confused. He was admitted to the hospital and had to be put into full time care. In March I had a dream where I see him in a house with barred windows. He is playing a hymn on a keyboard. The hymn is *Be Still My Soul*. I zoom in to where I can see his face more clearly and his look is so desperate and full of fear that I am jolted to wake up.
>
> Two things came out of this dream. He was in trouble and wanting help. I also had to admit that I was in trouble as well. I had some issues that I needed to work on with regards to him and the mess that he had left for me to sort out. In June, on one of my visits to see him, I saw the opportunity to talk to him about death and dying. For about 15 minutes, he was lucid and stayed with me in the conversation. I needed to know where he would like to be buried, etc. Was he afraid of dying? No, certainly

> not, he said "No, I'm not afraid: I'll be going home." In that time he thanked me for the conversation and for the suggestions I had made about his burial.
>
> In August, I [had] another dream. I am visiting a hospital and he is there, jumping around everywhere, doing back flips and somersaults. He lands in front of me and says, "I feel so well, I think I can go home soon." For me, "going home" is dying, so I took the hint, organized and paid for a funeral. At this stage he was being more settled and cooperative in the nursing home, engaging with the other residents more and being more like his old self. On the 15th of September he suffered a series of little strokes and died 3 days later. Of course, one of the hymns we played at his funeral was *Be Still My Soul.*
>
> I have no doubt at all that the series of dreams guided me to sort out my own unfinished business with him and also to assist him in his last days. The dreams guided me and supported me throughout the entire experience. Dreams, for me, are not just important, they are vital.

Another example of increased personal understanding through a word play in a dream is illustrated below.

> I dreamt I was inside my own image of my own real eye. When I examined the eye it moved about my face and landed on my nose. When I reflected on the symbolism of the dream, I realized, 'I'…'Knows!' It was a profound awakening that inspired more reflection on the importance of my taking/making time and space to reflect on my life's journey.

These examples provide additional evidence that GIM therapists value their dreams and the therapeutic potential of working with dreams in GIM, as previously indicated by the high

correlations between therapist attitudes, beliefs, and personal dreamwork and their frequency of using dreamwork activities in GIM.

Client examples. Several respondents shared examples of using dreamwork within the GIM session. One example shows a method for working with dreams in GIM and, as the respondent stated, it is used during GIM training.

> One client session stands out—she came to the session with a dream comprising three parts that were inner-related. In the first a large spider was underneath her bed and she felt afraid. In the second the spider had woven a web around the house in which her family lived. In the third part of the dream the spider gave her a message that "she" (the spider) would blow up the house. The client offered the thought that the spider represented the female authority figure at work and that work stress could threaten to damage the family. We took the dream as a focus, and I invited her to take any image of the dream as a focus image. She chose the large spider. She interacted with the spider in the music imagery segment, asking questions why it was there, and why it had a grotesque face. She uncovered vulnerability in the spider (the authoritarian female at work). At the end of the music I asked her how the spider looked now, and she said, "It's tiny." I use this example when teaching GIM trainees. It is almost a textbook example of how dreams can be used in a helpful way—where the GIM process enables the client to gain insight.

Another example illustrates a similar therapeutic outcome of understanding coming from using dream material in the GIM session.

> Client (born after 2nd World War in Germany) dreamed to have wanted to report something important to the police and parked her VW car there, but she was

> immediately imprisoned and felt lonesome and guilty for something, [although] she did not know the reason why. In the GIM session she found out that the VW was produced during Hitler's time (which she was not aware of before) and that the officials did not want to hear the truth about the Nazis. Therefore she had to keep quiet and bear the guilt of the Nazis.

The respondents' examples above provided detailed, honest, and sincere accounts of their own dreamwork and personal therapy. These responses demonstrate the value of using dreams in GIM, how dream images can be incorporated into the GIM session, and the therapeutic factors and benefit that result from combining these imagery methods.

CHAPTER 5

DISCUSSION AND CONCLUSIONS

This section will connect the quantitative and qualitative results with current practices from the field of psychotherapy. The author will discuss implications for GIM therapists, future research and training, and limitations of this study. The author will draw comparisons to previous survey studies in the field of dreamwork and psychotherapy.

Review of results

The results of this study support the original hypotheses of the study. Training in dreamwork was diverse, coming from readings, workshops, supervision, graduate courses, and personal dreamwork. The more training in dream interpretation the therapist had received, the higher the therapist rated the importance of working with dreams. Not surprisingly, GIM therapists who reported more training also felt more competent in working with dreams, supporting the previous findings from the verbal psychotherapy community (Crook & Hill, 2003; Hill et al., 2008; Schredl et al., 2000).

This study reveals types of clients and in what situations GIM therapists may be more likely to work with dreams. Respondents reported a high likelihood of working with dreams with various populations, including healthy clients, clients with depression or anxiety, clients with an adjustment disorder, and psychologically-minded clients. Working with several major types of dreams including recurrent dreams, troubling dreams or nightmares, and

pleasant dreams were highly rated and potentially addressed in therapy. GIM therapists were least likely to work with dreams with a client with a personality disorder.

Respondents rated the frequency of using specific dream activities during the three major sections of the GIM session. Their responses were not only consistent with previous verbal psychotherapy surveys of dreamwork, but also reflected the underlying nature of the GIM session, listening to and exploring images. The least used dream activity during the preliminary conversation was to interpret the dream based on unconscious wishes or to help clients change the dream. This was further evidenced by the responses to the prompts, in which several GIM therapists differentiated between their role of an interpreter and reported serving more as a supporter of the client's own interpretation. GIM stresses the importance of the imagery and music itself as agents of change and deemphasizes the need for analysis of images. The fewest dream activities were reported to be used during the postlude, which also follows the basic guidelines of what occurs during the postlude. The most frequent activity from the postlude was to collaborate with the client to construct a meaning of the dream. This is consistent with the Bonny method itself, which emphasizes a postlude collaboration between guide and traveler to explore imagery from the music and imagery session and draw connections with the client's life. Also consistent with the personal responses from the qualitative prompts was the low rated, less frequent dream activity of giving the client your understanding of what the dream means.

GIM therapists reported high agreement with several beliefs and attitudes about dreams. The responses to this section of the survey were clearly divided between high agreement to low or no agreement. None of the items reflected moderate agreement, indicating that there were apparent feelings one way or the other. The highest rated items

clearly conveyed that the respondents valued dreams, believed that dreams have meaning, and believed that dreams reflect waking life. The respondents agreed least with the notions that dreams are random firings in the brain or dreams are meaningless, and that they did not pay attention to their dreams. This agreement is consistent with the teaching of GIM. Several respondents reported their own thoughts that not all dreams represent therapeutic needs or necessarily have meaning, but they also stated their interest in dreamwork. These results suggest a need for clearer delineation between what types of dreams may be most beneficial to work on in therapy and what dreams may be less helpful for the client in dreamwork.

Respondents who reported positive attitudes toward dreams and who valued dreams also reported using dreams more frequently during several parts of the GIM session. The frequency of using dreams in therapy is consistent with Crook and Hill's (2003) study of dreamwork in verbal psychotherapy. GIM respondents who regarded dreams as meaningful were more likely to engage in dream activities in the preliminary conversation and during the postlude. Respondents who valued their dreams were shown to be more likely to employ dream activities during all aspects of the GIM session. Different dream activities that would be appropriate during the different parts of the GIM session were more frequently used by GIM therapists who value their dreams including educating the client on how they work with dreams or relating dream images to the client's life, imagery during GIM, or past experience. The less attention the respondent paid to his/her dreams, the less likely he/she was to use dreams in any way in the session, even to listen if a client brings in a dream; less than three respondents reported not paying attention to their dreams or agreed that dreams are meaningless. It would seem that most therapists would listen to dreams and perhaps lack of knowledge or indifference surrounding dreamwork led to these therapists making less use of

dreams in the sessions. Overall, listening to a client who brought in a dream was the highest rated dream activity, indicating that despite therapists' values or dreamwork training they would be most likely to listen, consistent with verbal psychotherapy training. The highest frequency of dream activities was reported to occur during the preliminary conversation, which is consistent with the findings of Grocke (2005).

The personal examples of using dreamwork in GIM or for personal work indicate that the topic of dreamwork in GIM has been explored by GIM therapists, even if the exploration is limited simply to thinking about dreams as another form of metaphor or paying attention to his/her own dreams. The respondents' clear indication that dreamwork would more likely occur if the client initiates or requests it is consistent with the findings from the verbal psychotherapist community (Crook & Hill, 2003). These personal stories give a broader picture of the value of using dreams in therapy and provide a sense of how GIM therapists currently utilize dream images within GIM.

Comparisons to previous survey research. The respondents in this survey provided results comparable to previous survey research on the topic of dreamwork in therapy. Keller et al. (1995) found that graduate training was the most frequently reported form of training for dreamwork; the present study found that fewer GIM respondents received dreamwork training through graduate courses. One reason for this divergence may be because GIM therapists have varied graduate emphases, many with an extensive education in music and music therapy, and dreamwork may have not been offered during their course of study. Readings and workshops were the most frequently reported sources of training, suggesting these respondents may be more inclined to self-directed educational experiences, similar to Schredl et al.'s (2000) findings. In regards to competence in dreamwork methods, the present

study used the same self-report measure of competence as Crook and Hill's (2003) survey. The mean level of competence was nearly identical in these two studies. These findings also support the relationship between therapists' perceived competence and dreamwork training.

The respondents in both the present study and that of Crook and Hill (2003) indicated when they would work with specific clients and types of dreams in therapy. The verbal psychotherapists surveyed by Crook and Hill reported the highest likelihood for working with dreams when a client presents a troubling dream; GIM therapist responded to this item similarly, though it was not the top dreamwork situation. The respondents in the Crook and Hill study and those in this study indicated likelihood of working with a client's recurring dream; the item was second highest in both groups of respondents and suggests that GIM therapists, like psychotherapists, recognize the implication of importance signified by recurrence of dreams. GIM therapists' were most likely to work with dreams with a healthy client seeking growth, which is not unexpected as many GIM clients begin GIM for this reason.

Similarities between Crook and Hill's (2003) survey and this study continued to the specific usage of dream activities. Like verbal psychotherapists, GIM therapists most frequently employ dreamwork by listening if a client brings in a dream (Crook & Hill, 2003; Hill et al., 2008). Crook and Hill found that the next two dream activities most frequently used were "explore connections of dream images to waking life" and "collaborate with clients to construct dream interpretation"; the GIM therapists who participated in this study rated those two items in the highest three during the postlude. The items from this study that were used more frequently in GIM sessions indicate areas that GIM therapists may focus on through training and clinical practice of using dreamwork in GIM.

Implications for GIM Practice

This study provides evidence that GIM therapists occasionally use dreams in GIM sessions. The qualitative responses describe instances of using dreams to assist in building trust and rapport, to bring forth topics for work, to aid in the selection of music and induction, and to provide a focus image for the GIM session. It is interesting that several examples described taking the dream image into the music and imagery, either as the actual focus image or as simply the topic of the preliminary conversation, and in these instances the images changed or were presented in another form. Themes from both dreams and the GIM imagery experience were similar but actual images were different.

Another implication for GIM therapists relates to how GIM therapists reported their training in dreamwork. GIM therapists wishing to work with dreams may begin by reading a book on dreamwork (e.g., Bosnak, 1988; Hall, 1983; Hill, 1996; or Johnson, 1986) or attending a workshop on the topic. The respondents for this study exemplified what is assumed about the self-directed learning exhibited by GIM therapists, as GIM training itself is post-baccalaureate, and often post-graduate, training and requires a high degree of independence and self-direction.

Limitations

There are several limitations of this study. One is that the questionnaire was only offered in English; since GIM sessions are facilitated internationally, respondents may have had confusion or may have been unfamiliar with the idioms used in the prompts. Additionally, the questionnaire itself, while being thorough, was lengthy, and respondents answered all or only some of the prompts. Respondents who were more interested in the topic of dreamwork and GIM may have participated more than those who were less

interested, thus creating a biased sample. Respondents also provided feedback indicating that future questionnaires should have more options for the multiple choice items including additional theoretical orientations, have clearer prompts, and be more concise (see Appendix C).

Suggestions for Future Research and Training

This study shows that there are GIM therapists who use dreams in conjunction with their GIM practice. There are currently no standards of training for educating GIM therapists on dreamwork techniques; it should be noted that several primary trainers do provide examples of dreamwork with GIM, as shown in the qualitative results and as reported by respondents in the quantitative results. Future work in this area may explore additional methods of using dreams in GIM, including suggestions for specific dreamwork activities during specific sections of the session. Additional research as to the efficacy of using dreams in GIM is needed to support using dreams with GIM. Another possibility for future exploration of this topic may be to create clinical training standards so that all GIM therapists have a basic knowledge of dreamwork techniques, especially those dreamwork techniques that increase the therapists' knowledge of working with imagery. Examining GIM and dreamwork from a multicultural standpoint would also enrich the training and practice of both fields. Future surveys may be offered in more languages to assist with clarity of questions and to avoid cultural idioms that might inhibit understanding.

Conclusion

Imagery in verbal psychotherapy has been shown to be an effective technique for facilitating therapeutic outcomes (Singer, 2006). The imagination is tapped into through meditation, relaxation, dreamwork, and GIM. Solely working with the presenting problem in

the moment may be necessary during times of crisis, but may not bring forth the full potential of therapy. GIM works primarily with images and music to facilitate lasting changes. Imagery is part of the whole human experience, and to ignore its potential in therapy would be to ignore the client's personal potential, including exploring areas where imagery overlaps in the client's life. When a client presents a dream in the GIM session, it is important for the GIM therapist to have tools for using dreams within the GIM session structure and knowledge of dreamwork to support the client's exploration of images. This study provides evidence that GIM therapists indeed use dreams in GIM sessions; training and personal values determine the likelihood of incorporating dreams into therapy. This study illuminated individual and cultural differences between GIM therapists' style and theoretical orientations, important considerations when developing a therapist training program or advanced competency. It also gave evidence of when and how to use dreams during the GIM session, for instance, by utilizing a dream image as the focus image. New possibilities for growth and understanding emerge by combining the powerful methods of dreamwork and GIM.

References

Abbott, E. A. (2007–2008). Facilitating guided imagery and music: What therapists intend, experience, and do. *Journal of the Association for Music and Imagery, 11,* 1–20.

Aserinsky, E., & Kleitman, N. (1953). Regularly occurring periods of eye motility and concomitant phenomena, during sleep. *Science, 118*(3062), 273–274. Retrieved from http://www.jstor.org/stable/1680525

Association for Music and Imagery. (2011). Frequently asked questions. Retrieved from http://www.ami-bonnymethod.org/faq.asp

Association for Music and Imagery. (2010). *Manual of standards and procedures for endorsement of the Bonny method of GIM trainers and training programs.* Chardon, OH: Author.

Atkins, S., Adams, M., McKinney, C., McKinney, H., Rose, L., Wentworth, J., & Woodworth, J. (2003). *Expressive arts therapy: Creative process in art and life.* Boone, NC: Parkway Publishers.

Bird, B. E. I. (2005). Understanding dreams and dreamers: An Adlerian perspective. *The Journal of Individual Psychology, 61*(3), 200–216.

Bonny, H. L. (2002a). Guided imagery and music (GIM): Discovery of the method. In L. Summer (Ed.), *Music & consciousness: The evolution of guided imagery and music* (pp. 43–52). Gilsum, NH: Barcelona Publishers.

Bonny, H. L. (2002b). Music and consciousness. In L. Summer (Ed.), *Music & consciousness: The evolution of guided imagery and music* (pp. 77–92). Gilsum, NH: Barcelona Publishers. (Reprinted from *Journal of Music Therapy, 12*, 121–135, 1975)

Bonny, H. L., & Kellogg, J. (2002). Guided imagery and music and the mandala: A case study illustrating an integration of music and art therapies. In L. Summer (Ed.), *Music & consciousness: The evolution of guided imagery and music* (pp. 205-230). Gilsum, NH: Barcelona Publishers. (Original work published 1977)

Bonny, H. L., & Pahnke, W. (2002). The use of music in psychedelic (LSD) psychotherapy. In L. Summer (Ed.), *Music & consciousness: The evolution of guided imagery and music* (pp. 19–41). Gilsum, NH: Barcelona Publishers. (Reprinted from *Journal of Music Therapy, 9*, 64–87, 1972)

Bosnak, R. (1988). *A little course in dreams.* Boston, MA: Shambhala.

Bruscia, K. E. & Grocke, D. E. (Eds.). (2002). *Guided imagery and music: The Bonny method and beyond.* Gilsum, NH: Barcelona Publishers.

Bush, C. A. (1988). Dreams, mandalas, and music imagery: Therapeutic uses in a case study. *The Arts in Psychotherapy, 15,* 219–225.

Bush, C. A. (1995). *Healing imagery & music: Pathways to the inner self.* Portland, OR: Rudra Press.

Cartwright, R. D. (1966). Dream and drug-induced fantasy behavior: A comparative study. *Archives of General Psychiatry, 15*(1), 7–15.

Cartwright, R. D. (2010). *The twenty-four hour mind: The role of sleep and dreaming in our emotional lives.* New York, NY: Oxford University Press.

Clark, M. F. (2002). Evolution of the Bonny Method of Guided Imagery and Music (GIM). In K. E. Bruscia & D. E. Groke (Eds.), *Guided imagery and music: The Bonny method and beyond* (pp. 5–27). Gilsum, NH: Barcelona Publishers.

Clarkson, G. (2002) Combining gestalt dreamwork and the Bonny method. In K. E. Bruscia & D. E. Grocke (Eds.), *Guided imagery and music: The Bonny method and beyond* (pp. 245–226). Gilsum, NH: Barcelona Publishers.

Crook, R. E., & Hill, C. E. (2003). Working with dreams in psychotherapy: The therapists' perspective. *Dreaming, 13*(2), 83–93.

Davis, J. (1995). Processing dream images within the context of art therapy as an approach to personality integration. *Pratt Institute Creative Arts Therapy Review, 16*, 57–63.

Dolias, L. (2010). Bad dreams are made of this: Looking at distressing dreams in light of Heidegger's befindlichkeit and Boss' dream theories. *Existential Analysis: Journal of the Society for Existential Analysis, 21*, 238–250.

Dushman, R. D., & Sutherland, J. (1997). An Adlerian perspective on dreamwork and creative arts therapies. *Individual Psychology, 53*, 461–475.

Eudell-Simmons, E. M., & Hilsenroth, M. J. (2007). The use of dreams in psychotherapy: An integrative model. *Journal of Psychotherapy Integration, 17*, 330–356. doi:10.1037/1053-0479.17.4.330

Freud, S. (1999). *The interpretation of dreams* (J. Crick, Trans.). New York, NY: Oxford. (Original work published in 1900)

Grocke, D. (2005). The role of the therapist in the Bonny Method of Guided Imagery and Music (GIM). *Music Therapy Perspectives, 23,* 45–52.

Hall, J. A. (1983). *Jungian dream interpretation: A handbook of theory and practice.* Toronto, Canada: Inner City Books.

Hill, C. E. (1996). *Working with dreams in psychotherapy*. New York, NY: The Guilford Press.

Hill, C. E., Liu, J., Spangler, P., Sim, W., & Schottenbauer, M. (2008). Working with dreams in psychotherapy: What do psychoanalytic therapists report that they do? *Psychoanalytic Psychology, 25*, 565–573.

Jacobi, J. (1964). Symbols in an individual analysis. In C. Jung (Ed.), *Man and his symbols* (pp. 321–374). London, England: Aldus Books.

Johnson, R. (1986). *Inner work: Using dreams and active imagination for personal growth.* New York, NY: Harper One.

Jung, C. G. (1964). Approaching the unconscious. In C. Jung (Ed.), *Man and his symbols* (pp. 1–94). London, England: Aldus Books.

Jung, C. G. (1969). *The archetypes and the collective unconscious* (2nd ed.). (R. F. C. Hull, Trans.). New York, NY: Princeton University Press.

Keller, J. W., Brown, G., Maier, K., Steinfurth, K., Hall, S., & Piotrowski, C. (1995). Use of dreams in therapy: A survey of clinicians in private practice. *Psychological Reports, 76*, 1288–1290.

Lewis, K. (2002). The development of training in the Bonny Method of Guided Imagery and Music (GIM) from 1975–2000. In K. E. Bruscia & D. E. Grocke (Eds.), *Guided imagery and music: The Bonny method and beyond* (pp. 497–517). Gilsum, NH: Barcelona Publishers.

Lin, M. F., Hsu, M. C., Chang, H. J., Hsu, Y. Y., Chou, M. H., & Crawford, P. (2010). Pivotal moments and changes in the Bonny method of guided imagery and music for patients with depression. *Journal of Clinical Nursing, 19,* 1139–1148. doi: 10.1111/j.1365-2702.2009.03140.x

McKinney, C. H. (2011). *Training manual for the Bonny method of guided imagery and music: Level III, music.* Unpublished manuscript, Hayes School of Music, Appalachian State University, Boone, NC.

Meadows, A. (2002). Distinctions between the Bonny Method of Guided Imagery and Music (GIM) and other imagery techniques. In K. E. Bruscia & D. E. Grocke (Eds.), *Guided imagery and music: The Bonny method and beyond* (pp. 63–83). Gilsum, NH: Barcelona Publishers.

Montangero, J. (2009). Using dreams in cognitive behavioral psychotherapy: Theory, method, and examples. *Dreaming, 19*, 239–254. doi:10.1037/a0017613

Palagini, L., & Rosenlicht, N. (2011). Sleep, dreaming, and mental health: A review of historical and neurobiological perspectives. *Sleep Medicine Reviews, 15*, 179–186. doi:10.1016/j.smrv.2010.07.003

Perls, F. S. (1969). *Gestalt therapy verbatim*. Moab, UT: Real People Press.

Powell, L. T. (2007–2008). An adaptation of the Bonny method of guided imagery and music for public schools. *Journal of the Association for Music and Imagery, 11*, 65–78.

Priestley, M. (1994). *Essays on analytical music therapy*. Phoenixville, PA: Barcelona Publishers.

Schredl, M., Bohusch, C., Kahl, J., Mader, A., & Somesan, A. (2000). The use of dreams in psychotherapy: A survey of psychotherapists in private practice. *The Journal of Psychotherapy Practice and Research, 9,* 81–87.

Singer, J. L. (2006). *Imagery in psychotherapy.* Washington, DC: American Psychological Association.

Summer, L. (1988). *Guided imagery and music in the institutional setting*. St. Louis, MO: MMB Music.

Trondalen, G. (2009–2010). Exploring the rucksack of sadness: Focused, time-limited Bonny method of guided imagery and music with a female executive. *Journal of the Association for Music and Imagery, 12,* 1–20.

Ventre, M. (2002). The individual form of the Bonny method of guided imagery and music. In K. E. Bruscia, & D. E. Grocke (Eds.), *Guided imagery and music: The Bonny method and beyond* (pp. 29–35). Gilsum, NH: Barcelona Publishers.

Wärja, M. (1994). Sounds of music through the spiraling path of individuation: A Jungian approach to music psychotherapy. *Music Therapy Perspectives, 12*, 75–83.

APPENDICES

Appendix A

E-mail Sent to Potential Respondents

Hello,

As a therapist who provides the Bonny Method of Guided Imagery and Music sessions, you are invited to participate in a survey that concerns your practices as a GIM therapist and dreamwork. This survey is part of my thesis research on the use of dreamwork in Guided Imagery and Music sessions, which I am conducting at Appalachian State University. This survey was approved Dec. 13, 2011 by the University's IRB.

The information you provide will remain completely anonymous. You will be asked to provide basic demographic information. The website (Google Docs) where the survey is located is a secure site, and it neither stores nor tracks your email address, nor does it attach your email address to your responses. The researcher will have no access to email addresses of those who participate or do not participate in the study and the researcher will not have the ability to link e-mail addresses to responses. The anonymous data will be included in the researcher's master's thesis, and the study may be submitted for publication in a professional journal.

No risks are associated with completing this survey and you will receive no compensation. Your participation in this study is completely voluntary.

If you are willing to participate, please continue to access the online survey. By submitting responses to the survey you are consenting to participate. You can choose to respond to all, some, or none of the items. The questionnaire will take approximately 20 minutes to complete.
Please complete the survey by February 15, 2012.

Questions may be directed to myself, Carole Deans, at deanscm@appstate.edu or Dr. Cathy McKinney, Faculty Advisor, mckinnych@appstate.edu.

Thank you for your participation.

Sincerely,

Carole Deans, MT-BC
Candidate for Master of Music Therapy degree
Advanced Trainee in the Bonny Method of GIM

Appendix B

Dreamwork with Guided Imagery and Music Questionnaire

As a therapist who provides the Bonny Method of Guided Imagery and Music sessions, you are invited to participate in this survey that concerns your practices of GIM. You will also be asked to provide demographic information. This survey is part of my thesis research being conducted at Appalachian State University and has been approved by the University's IRB.
Please note that the questions are specific to your GIM work. This survey will take approximately 20 minutes to complete. Thank you for your participation. Questions regarding this survey may be directed to Carole Deans at deanscm@appstate.edu. This survey was adapted from the Therapist Dream Questionnaire by Crook & Hill (2003).
* Required

Gender: *

☐ Female
☐ Male

Age: *
☐

Country *
☐

Highest Educational Degree Obtained *

☐ MA
☐ MMT
☐ Doctoral degree
☐ Other:

Indicate your GIM credentials or training level: *

☐ FAMI (Fellow of the Association for Music and Imagery) or RGIMT
☐ Advanced Trainee (Level III) or Grad Diploma in GIM

Primary Work Setting *

☐ Private Practice
☐ Agency/Hospital
☐ University/Academic
☐ Other:☐

***If you have not seen GIM clients in the past year, please stop here.**

How many years have you facilitated guided imagery and music sessions?
Include years of advanced training sessions.
☐

How many hours per week do you see clients for GIM?
☐

Rate the extent to which you believe in and adhere to the theory and techniques of each of the following theoretical orientations:
1 = Low; 5 = High

	1	2	3	4	5
Psychoanalytic/ Psychodynamic					
Humanistic/ Existential					
Behavioral/ Cognitive Behavioral					

Rate how much training you have had in dream interpretation.
Include in your estimate such things as workshops, supervision, reading, and graduate courses:

	1	2	3	4	5	
No training						Extensive training

Indicate the specific type of training in dreamwork you have had:

- ☐ Graduate courses
- ☐ Workshop/ Seminar
- ☐ Supervision
- ☐ Reading
- ☐ Working with your own dreams
- ☐ Other:☐

How competent do you feel working with dreams in therapy?

	1	2	3	4	5	
Not at all competent						Extremely competent

Overall, how important do you think it is to work with dreams in therapy?

	1	2	3	4	5	
Not important						Very important

What percentage of your GIM clients have brought dreams into sessions in the past year?
☐

Overall, what is your best estimate of the percentage of time that you actually spend in GIM sessions working with your clients' dreams?
Include music and imagery time when the dream provides the focus image.
☐

Indicate how much you typically do the following activities during the preliminary conversation in individual GIM sessions:
1 = Never; 5 = Frequently

	1	2	3	4	5
Mention that you are willing to work with dreams:					
Explain how you work with dreams:					
Invite client to tell a dream:					
Listen if client brings in a dream:					
Encourage client to associate to dream images (e.g. say whatever comes to mind):					
Ask client to describe images in greater detail:					
Ask client for triggers in waking life to dream images:					
Collaborate with client to construct a meaning of the dream:					
Relate the dream to client's current waking life experience					
Relate the dream to past experiences in the client's life:					
Work with conflicts that are represented in dreams:					
Ask client to act out different parts of the dream:					
Interpret dream according to unconscious wishes:					
Interpret dream according to archetypes:					
Relate dream to spiritual beliefs:					
Help client try to change the dream:					
Use dream images as metaphors later in therapy:					
Interpret dream in terms of the therapy relationship:					

Indicate how much you typically do the following activities during the induction, focus image, or music and imagery experience in individual GIM sessions:
1 = Never; 5 = Frequently

	1	2	3	4	5
Encourage client to re-experience feelings from a dream:					
Work with conflicts that are represented in dreams:					
Use dream images as metaphors later in therapy:					
Use a dream image as the focus image:					
Use the dream themes/ feelings to determine the music program:					
Use dream feeling as the focus image:					

Indicate how much you typically do the following activities during the postlude in individual GIM sessions:
1 = Never; 5 = Frequently

	1	2	3	4	5
Give client your understanding of what the dream means:					
Collaborate with client to construct a meaning of the dream:					
Relate the dream to client's current waking life experience					
Relate the dream to past experiences in the client's life:					
Interpret dream according to unconscious wishes:					
Interpret dream according to archetypes:					
Relate dream to spiritual beliefs:					
Suggest to client what changes s/he could make based on learnings from the dream:					
Work with client to develop ideas for making changes based on what s/he learned in the dream:					
Interpret dream in terms of the therapy relationship:					
Compare the dream images with the GIM imagery experience:					

Indicate how likely you would be to work with dreams within the GIM session in the following situations:
1 = Not likely; 5 = Very likely

	1	2	3	4	5
Client presents recurrent dreams:					
Client presents troubling dreams or nightmares:					
Client is interested in learning about his/her dreams:					
We are at an impasse in therapy or "stuck":					
I have a dream about the client:					
Have plenty of time in long-term therapy:					
Client is willing to work with dreams:					
Client presents dream as a way of avoiding important life issues:					
Client presents a pleasant dream:					

What are other factors, situations, or circumstances that would lead you to work with dreams in the GIM session?
☐

Indicate how likely you would be to work with dreams in GIM sessions with the following types of clients:
1 = Not likely; 5 = Very likely

	1	2	3	4	5
Healthy client seeking growth:					
Client with adjustment disorder:					
Client with personality disorder:					
Client with depression/ anxiety:					
Client with substance abuse problem:					
Client with Post-Traumatic Stress Disorder (PTSD):					
Psychologically-minded client:					
Not psychologically-minded client:					
Clients with recurrent nightmares:					

GIM Therapist's Attitude Toward Dreams
The following items relate to your personal view of dreamwork.

Indicate how much you believe each of the following statements about the functions of dreams:
1 = Strongly disagree; 5 = Strongly agree

	1	2	3	4	5
Dreams represent unconscious messages:					
Dreams are due to random firings in the brain:					
Dreams reflect waking life:					
Dreams are meaningless:					
Dreams represent the brain's attempt to purge unneeded connections:					
Dreams are attempts at problem solving:					
Dreams are messages from external sources (i.e. God, devil, deceased relatives):					

During the last two weeks, immediately upon waking up in the morning, how often could you recall dreaming?
Please check one

- ☐ Every morning
- ☐ Just about every morning
- ☐ Most mornings
- ☐ About every other morning
- ☐ About two mornings per week
- ☐ About one morning per week
- ☐ Once during the two weeks
- ☐ Not once

How often do you usually have dreams that you remember?
Please check one

- ☐ About every night
- ☐ 2-3 times a week
- ☐ Almost once a week
- ☐ 1-2 times a month
- ☐ less than once a month

Rate how much you have worked with your own dreams in your own therapy, including personal GIM sessions, throughout your life:
Please check one

- ☐ Never
- ☐ Rarely
- ☐ Some
- ☐ Often
- ☐ Extensively

Indicate how much you do each of the following activities with your own dreams:
1 = Never; 5 = Frequently

	1	2	3	4	5
Keep a dream journal					
Try to figure out dreams on your own					
Talk about salient dreams with a colleague, friend, partner, or therapist					

Rate your attitudes about dreams:
1 = Strongly disagree; 5 = Strongly agree

	1	2	3	4	5
I believe that dreams are one of the most important ways to understand myself:					
I do not pay any attention to my own dreams:					
Dreams have meaning:					
Dreams are too confusing to have any meaning to me:					
I dislike speculation about the meaning of dreams:					
I value my dreams:					
Practical everyday life is too important to me to pay attention to my dreams:					

What other thoughts do you have about working with dreams with Guided Imagery and Music?

_____

If you wish, cite an example of personal work (as the client/ traveler) with dreams in GIM:

_____

Thank you for completing this survey!

Questionnaire adapted from:
Crook, R. E., & Hill, C. E. (2003). Working with dreams in psychotherapy: The therapists' perspective. Dreaming, 13(2), 83-93.

Appendix C

Additional Responses to Qualitative Prompts

What other thoughts do you have about working with dreams within Guided Imagery and Music sessions?

- I think the study of dreams is very important when working with GIM and other types of psychotherapy. I am very interested in finding a training to give me knowledge about working with dreams. It is one of my goals. Thanks for your investigation. I'd like to have access to the results of this work. Thank you very much.
- In my limited experience with dream work and as a GIM therapist I have found that engaging in working on client's dreams helps to build trust and rapport. Working collaboratively on dreams has proven to be a validating experience for the client.
- Working with dreams in GIM will be more powerful, helpful, healing and releasing when there is more active work around the GIM process. Such as working with arts, creative writing, and most important—doing body oriented work. Paying attention to the body in the whole session is essential!
- I often explain GIM as a similar process to dreaming while awake, and point out that GIM allows time to stay with images, and to interact with them.
- I feel forced into either/or answers by these polarized questions. I do not think all dreams are created equal. Rather, different dreams have different qualities, purposes, and causes. While some have brilliant clarity that may be precognitive, prescient, or tap archetypal realms, others may very well be due to random firings in the brain (e.g., those resulting from high fever during a bad cold)…. Regardless, you are asking important questions. I hope I have an opportunity to learn the outcome of your study. Thank you.
- I do not focus the clients on a dream unless they bring one in….
- I am not at all opposed to the use of dreamwork in GIM or any other kind of therapy. I don't feel like I have enough training in this area, but when clients present dreams, I treat them like any other image: I help them make their own meanings out of the experience. I don't know that it would be necessary to be trained in dream interpretation, but perhaps more training on integrating dreamwork into GIM practice would be welcome.
- Exploring dream images, conflicts and feelings with the use of GIM has proven to be extremely valuable and healing to clients (and myself).
- Dreams can be utilized in many ways in the GIM work….
- I work with dreams when necessary for the client. How deep depends on the goal. People with weak Ego strength need [additional] emotional support than others, therefore my dreamwork techniques can be very actively directed (role play of symbols) or open exploring.
- It is dealing with similar, if not identical, psychological material. I believe dreams can be continued through GIM and also GIM sessions can be continued through dream—

and often are. Similarly, other non-verbal arts can go in both directions. The beauty of GIM is that with a transcribing witness/guide, most of the details can be captured and the dreamer/traveler does not have to rely on shaky memory. For myself, I am not a very prolific dreamer and even if I try to capture them in the middle of the night, I find I cannot get into my left brain to get any words to write down.

- Would love to see the Jungian community available for conversation around dreamwork and GIM.
- Any process that increases the narrative of the dream is beneficial and GIM and dreaming have so much in common that they both present strong images that reflect the life of the dreamer/traveler, that it would be failing the client not to use them. At the same time, I stay away from interpretation. I have learned how to ask questions that may help the client "join the dots," for themselves. Some of your questions above confused me somewhat because they implied that I had to say how much I "relate" interpretations to the client. I believe that the dream belongs to the dreamer and while I can assist them to relate the dream and its message, it is not up to me to decide what the meaning might be.
- Most of my experience is within my own therapy. I think that dreamwork can be a good starting point or focus for the music listening. I find that it is a lot easier to work with the images in the music than with dream images. Dream images are so unclear and obscure and the beauty of GIM is the powerful metaphor created in collaboration with the music and with the clients, ego must [be] present.
- This survey has alerted me to the fact that I under-use my client's dreams (salient dreams) in GIM sessions and that dreams are so suited to work with, specifically through GIM. I believe that any dream one remembers well, stays with you, reoccurs, wakes you up, etc. is really important and provides much insight, although I do not believe that every single dream is significant.
- My most recent clients (a couple of years ago) didn't often bring their dreams into sessions. If they did, I attempted to hear the metaphors in the dreams and connect them with what I understood of the client's situation. As best as I can recall, usually the dreams did not provide new information, but perhaps added an additional perspective of how the client felt, and thus a new entry point for imagery work.
- I believe we tap a similar metaphoric world. Dreams can be deeper, more symbolic. GIM, especially visual travelers, speak in metaphor, the same language as dreams. Yet even kinesthetic travelers are stimulated to recall more dreams.
- As a humanistic psychologist I am interested in the holistic view that the client's dream offer. Between body and mind, soul and spirit, emotions and thoughts. Dreams provide the therapist with considerable material to develop the client's awareness about the polarities and existential fear about life.
- I like to work with dreams when a client feels it is important. It really has depended on the particular client and situation. I enjoy working with dreams and dream material.

- I believe that those unresolved issues in our lives appear in the dreams and we need to tend to the unfolding of them, they are indicators of our inner life with both consonance and dissonance occurring in them.
- The cue for me is always that the client brings a dream and shows engagement in working with it.
- In [country] the field of psychology is very cognitively oriented. Work with dreams is looked at as old-fashioned and a bit unprofessional. This is not my own view but one is always affected by the paradigm in which one exists.
- I felt there were many questions connected to my interpretation of a client's dream. The interpretation of any images (dreams or images generated in music), mainly comes from my clients, not from me.

If you wish, cite an example of personal work (as client/traveler) with dreams and GIM:

- A client recalled a dream from her early childhood (3–4 years old). In the dream she was being chased by a retractable metal tape measure. The tape measure chased her across the snow and she was terrified. I asked her if she thought the dream was related to her low self-esteem and the belief that she didn't "measure up." She felt validated by my response because that was her own gut feeling about the dream.
- Other comment: I wish there would have been more options to comment on my theoretical orientation. I practice using a feminist approach to GIM, which was not listed above. And from this experience, a client's lived experience and subjective world is valued. This is also a collaborative method, so it ahs less to do with how I feel about dreams personally than what the client needs and how we collaborate throughout the GIM experience in terms of incorporation of dreamwork, etc. into the session. Thus I selected "humanistic/existential" which leans more towards client-centeredness, but this does not fully describe my belief in an egalitarian and collaborative method.
- I think this survey was far too long and not clear in the questioning.
- I am 53 and have been doing therapy since I was 25. I am positive I have used dreams in GIM, but truthfully, cannot recall a specific time.
- My dream life waxes and wanes in different periods of my life. At times I have been very active—keeping a dream journal and actively working on my dreams, I'd say about 2-3 times a week using personal music and imagery. At that time I was practicing GIM more actively, too. In the last few years my recall of dreams diminished considerably and my practice is not as active so both my personal and professional work with dreams is reduced. I actively help supervisees to address their clients' dreams in sessions, especially at the beginning of the GIM process.
- I don't believe I brought many of my own dreams into my own GIM work. At the moment I'm not able to recall any specific examples, unfortunately. If I did so, I believe it probably occurred at the beginning of my first long series of sessions, my first foray into deep personal work.

- Unfortunately no one in my circle of colleagues did much with dreams when I was actively having sessions. I work with my own but also share my own dreams in a group dream setting, when appropriate.
- [I] used a dream of myself as a child to explore family issues. It was helpful. [I] did a lot of grief work in my dreams after 2 major losses in my life. [I] did not use these dreams in GIM work, however. [I] used journaling and talking with a therapist to process these.

BIOGRAPHICAL SKETCH

Carole Margaret Deans was born in Louisville, KY on February 5, 1982. She began her formal study of music at age four with violin and later moved her musical concentration to the piano. She graduated from Myers Park High School in Charlotte, NC with an International Baccalaureate degree with focus areas in music and theatre. Ms. Deans completed her undergraduate studies in 2005, graduating cum laude with a Bachelor of Science in Psychology, a Bachelor of Music in Music Therapy, and a minor in Women's Studies from Appalachian State University, Boone, NC. In 2003 she began her study of the Bonny Method of Guided Imagery and Music with the completion of Level I. From 2005 to 2009, Ms. Deans worked as a music therapist with children and adults with developmental and intellectual disabilities, hospice, and general medical settings. In 2009, she began her graduate studies at Appalachian in the fields of clinical mental health counseling and music therapy with an emphasis on expressive arts therapy. She became interested in dreams during her graduate studies at Appalachian; Ms. Deans completed a course on clinical dreamwork with Dr. Joan Woodworth in 2009 and an additional course entitled Dreams, Art, and Nature with Dr. Sally Atkins and Dr. Harold McKinney in 2011. Ms. Deans also began her advanced training in GIM in 2011. In May 2012, she will graduate with double Masters degrees in clinical mental health counseling and music therapy. She plans to continue her training in GIM and begin a small private practice in Boone, NC.

Ms. Deans is a member of the Association for Music and Imagery, the American Counseling Association, the American Music Therapy Association, and the Music Therapy Association of North Carolina. She has also been inducted into Pi Kappa Lambda and Chi Sigma Iota. Later this year she will marry Jonathan Davis Greene; her parents are Reverends Parke and Margaret Deans of Abingdon, VA.